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

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Clerk of Supreme Court

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

## APPELLANTS' APPENDIX
## VOLUME 76
## PAGES 18,751–19,000

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## CHRONOLOGICAL TABLE OF CONTENTS TO APPENDIX


| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 1. | Complaint (Business Court) | 04/15/19 | 1 | 1–17 |
| 2. | Peremptory Challenge of Judge | 04/17/19 | 1 | 18–19 |
| 3. | Summons - UMR, Inc. dba United Medical Resources | 04/25/19 | 1 | 20–22 |
| 4. | Summons – United Health Care Services Inc. dba UnitedHealthcare | 04/25/19 | 1 | 23–25 |
| 5. | Summons – United Healthcare Insurance Company | 04/25/19 | 1 | 26–28 |
| 6. | Summons – Health Plan of Nevada, Inc. | 04/30/19 | 1 | 29–31 |
| 7. | Summons – Sierra Health-Care Options, Inc. | 04/30/19 | 1 | 32–34 |
| 8. | Summons – Sierra Health and Life Insurance Company, Inc. | 04/30/19 | 1 | 35–37 |
| 9. | Summons – Oxford Health Plans, Inc. | 05/06/19 | 1 | 38–41 |
| 10. | Notice of Removal to Federal Court | 05/14/19 | 1 | 42–100 |
| 11. | Motion to Remand | 05/24/19 | 1 | 101–122 |
| 12. | Defendants' Statement of Removal | 05/30/19 | 1 | 123–126 |
| 13. | Freemont Emergency Services (MANDAVIA), Ltd's Response to Statement of Removal | 05/31/19 | 1 | 127–138 |
| 14. | Defendants' Opposition to Fremont Emergency Services (MANDAVIA), Ltd.'s Motion to Remand | 06/21/19 | 1<br>2 | 139–250<br>251–275 |
| 15. | Rely in Support of Motion to Remand | 06/28/19 | 2 | 276–308 |
| 16. | Civil Order to Statistically Close Case | 12/10/19 | 2 | 309 |
| 17. | Amended Motion to Remand | 01/15/20 | 2 | 310–348 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 18. | Defendants' Opposition to Plaintiffs' Amended Motion to Remand | 01/29/20 | 2 | 349–485 |
| 19. | Reply in Support of Amended Motion to Remand | 02/05/20 | 2<br>3 | 486–500<br>501–518 |
| 20. | Order | 02/20/20 | 3 | 519–524 |
| 21. | Order | 02/24/20 | 3 | 525–542 |
| 22. | Notice of Entry of Order Re: Remand | 02/27/20 | 3 | 543–552 |
| 23. | Defendants' Motion to Dismiss | 03/12/20 | 3 | 553–698 |
| 24. | Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief | 03/13/20 | 3<br>4 | 699–750<br>751 |
| 25. | Plaintiffs' Opposition to Defendants' Motion to Dismiss | 03/26/20 | 4 | 752–783 |
| 26. | Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss | 03/26/20 | 4 | 784–908 |
| 27. | Recorder's Transcript of Proceedings Re: Motions | 04/03/20 | 4 | 909–918 |
| 28. | Defendants' Reply in Support of Motion to Dismiss | 05/07/20 | 4 | 919–948 |
| 29. | Recorder's Transcript of Proceedings Re: Pending Motions | 05/14/20 | 4 | 949-972 |
| 30. | First Amended Complaint | 05/15/20 | 4<br>5 | 973–1000<br>1001–1021 |
| 31. | Recorder's Transcript of Hearing All Pending Motions | 05/15/20 | 5 | 1022–1026 |
| 32. | Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint | 05/26/20 | 5 | 1027–1172 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 33. | Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief | 05/26/20 | 5 | 1173–1187 |
| 34. | Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint | 05/29/20 | 5<br>6 | 1188–1250<br>1251–1293 |
| 35. | Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief | 05/29/20 | 6 | 1294–1309 |
| 36. | Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint | 06/03/20 | 6 | 1310–1339 |
| 37. | Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint | 06/03/20 | 6 | 1340–1349 |
| 38. | Transcript of Proceedings, All Pending Motions | 06/05/20 | 6 | 1350–1384 |
| 39. | Transcript of Proceedings, All Pending Motions | 06/09/20 | 6 | 1385–1471 |
| 40. | Notice of Entry of Order Denying Defendants' (1) Motion to Dismiss First Amended Complaint; and (2) Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief | 06/24/20 | 6<br>7 | 1472–1500<br>1501–1516 |
| 41. | Notice of Entry of Stipulated Confidentiality and Protective Order | 06/24/20 | 7 | 1517–1540 |
| 42. | Defendants' Answer to Plaintiffs' First Amended Complaint | 07/08/20 | 7 | 1541–1590 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 43. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 07/09/20 | 7 | 1591–1605 |
| 44. | Joint Case Conference Report | 07/17/20 | 7 | 1606–1627 |
| 45. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 07/23/20 | 7 | 1628–1643 |
| 46. | Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement | 07/29/20 | 7 | 1644–1663 |
| 47. | Amended Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement | 07/29/20 | 7 | 1664–1683 |
| 48. | Errata | 08/04/20 | 7 | 1684 |
| 49. | Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, or, in the Alternative, Motion in Limine on Order Shortening Time | 08/28/20 | 7<br>8 | 1685–1700<br>1701–1845 |
| 50. | Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, Or, in The Alternative, Motion in Limine on Order Shortening Time | 09/04/20 | 8 | 1846–1932 |
| 51. | Recorder's Transcript of Proceedings Re: Pending Motions | 09/09/20 | 8 | 1933–1997 |
| 52. | Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | 09/21/20 | 8<br>9 | 1998–2000<br>2001–2183 |
| 53. | Notice of Entry of Order Granting, in Part Plaintiffs' Motion to Compel Defendants' Production of Claims for At-Issue Claims, | 09/28/20 | 9 | 2184–2195 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Or, in The Alternative, Motion in Limine | | | |
| 54. | Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories | 09/28/20 | 9 | 2196–2223 |
| 55. | Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | 09/29/20 | 9-10 | 2224–2292 |
| 56. | Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time | 10/06/20 | 10 | 2293–2336 |
| 57. | Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures | 10/07/20 | 10 | 2337–2362 |
| 58. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 10/08/20 | 10 | 2363–2446 |
| 59. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 10/22/20 | 10 | 2447–2481 |
| 60. | Defendants' Objections to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/23/20 | 10<br>11 | 2482–2500<br>2501–2572 |
| 61. | Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/26/20 | 11 | 2573–2670 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 62. | Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time | 10/27/20 | 11 | 2671–2683 |
| 63. | Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/27/20 | 11 | 2684–2695 |
| 64. | Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs' to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | 11/02/20 | 11 | 2696–2744 |
| 65. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 11/04/20 | 11<br>12 | 2745–2750<br>2751–2774 |
| 66. | Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 11/09/20 | 12 | 2775–2785 |
| 67. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 12/23/20 | 12 | 2786–2838 |
| 68. | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 12/30/20 | 12 | 2839–2859 |
| 69. | Notice of Entry of Stipulated Electronically Stored Information Protocol Order | 01/08/21 | 12 | 2860–2874 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 70. | Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/08/21 | 12<br>13<br>14 | 2875–3000<br>3001–3250<br>3251–3397 |
| 71. | Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/11/21 | 14 | 3398–3419 |
| 72. | Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/12/21 | 14 | 3420–3438 |
| 73. | Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only) | 01/13/21 | 14 | 3439–3448 |
| 74. | Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/19/21 | 14 | 3449–3465 |
| 75. | Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/19/21 | 14<br>15 | 3466–3500<br>3501–3658 |
| 76. | Recorder's Transcript of Proceedings Re: Motions | 01/21/21 | 15 | 3659–3692 |
| 77. | Notice of Entry of Order Granting Defendants' Motion for Appointment of Special Master | 02/02/21 | 15 | 3693–3702 |
| 78. | Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 02/04/21 | 15 | 3703–3713 |
| 79. | Motion for Reconsideration of Order Denying Defendants' Motion to Compel | 02/18/21 | 15<br>16 | 3714–3750<br>3751–3756 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Plaintiffs Responses to Defendants' First and Second Requests for Production | | | |
| 80. | Recorder's Transcript of Proceedings Re: Motions | 02/22/21 | 16 | 3757–3769 |
| 81. | Recorder's Transcript of Proceedings Re: Motions | 02/25/21 | 16 | 3770–3823 |
| 82. | Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request) | 03/03/21 | 16 | 3824–3832 |
| 83. | Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production | 03/04/21 | 16 | 3833–3862 |
| 84. | Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 03/08/21 | 16 | 3863–3883 |
| 85. | Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 03/12/21 | 16 | 3884–3886 |
| 86. | Notice of Entry of Report and Recommendation #1 | 03/16/21 | 16 | 3887–3894 |
| 87. | Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production | 03/16/21 | 16 | 3895–3909 |
| 88. | Recorder's Transcript of Hearing All Pending Motions | 03/18/21 | 16 | 3910–3915 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 89. | Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not be Held in Contempt and for Sanctions | 03/22/21 | 16 | 3916–3966 |
| 90. | Recorder's Transcript of Hearing All Pending Motions | 03/25/21 | 16 | 3967–3970 |
| 91. | Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order | 03/29/21 | 16 | 3971–3980 |
| 92. | Recorder's Transcript of Hearing Motion to Associate Counsel on OST | 04/01/21 | 16 | 3981–3986 |
| 93. | Recorder's Transcript of Proceedings Re: Motions | 04/09/21 | 16<br>17 | 3987–4000<br>4001–4058 |
| 94. | Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order | 04/12/21 | 17 | 4059–4079 |
| 95. | Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time | 04/15/21 | 17 | 4080–4091 |
| 96. | Recorder's Transcript of Hearing All Pending Motions | 04/21/21 | 17 | 4092–4095 |
| 97. | Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to | 04/26/21 | 17 | 4096–4108 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Defendants' First and Second Requests for Production | | | |
| 98. | Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time | 04/28/21 | 17 | 4109–4123 |
| 99. | Defendants' Errata to Their Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production | 05/03/21 | 17 | 4124–4127 |
| 100. | Defendants' Objections to Plaintiffs' Proposed Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 05/05/21 | 17 | 4128–4154 |
| 101. | Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form | 05/12/21 | 17 | 4155–4156 |
| 102. | Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question | 05/26/21 | 17 | 4157–4165 |
| 103. | Recorder's Transcript of Proceedings Re: Motions | 05/28/21 | 17 | 4166–4172 |
| 104. | Notice of Entry of Report and Recommendation #7 Regarding Defendants' | 06/03/21 | 17 | 4173–4184 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents | | | |
| 105. | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/03/21 | 17 | 4185–4209 |
| 106. | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/04/21 | 17 | 4210–4223 |
| 107. | Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form | 06/09/21 | 17 | 4224–4226 |
| 108. | Defendants' Objections to Special Master Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Requests for Production of Documents | 06/17/21 | 17 | 4227–4239 |
| 109. | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/23/21 | 17<br>18 | 4240–4250<br>4251–4280 |
| 110. | Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended Third Set of Request for Production of Documents | 06/24/21 | 18 | 4281–4312 |
| 111. | Notice of Entry Report and Recommendations #9 Regarding Pending Motions | 07/01/21 | 18 | 4313–4325 |
| 112. | United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents | 07/12/21 | 18 | 4326–4340 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | About Which Plaintiffs' Witnesses Testified on Order Shortening Time | | | |
| 113. | Recorder's Transcript of Proceedings Re: Motions Hearing | 07/29/21 | 18 | 4341–4382 |
| 114. | Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 08/03/21 | 18 | 4383–4402 |
| 115. | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection | 08/09/21 | 18 | 4403–4413 |
| 116. | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection | 08/09/21 | 18 | 4414–4424 |
| 117. | Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection | 08/09/21 | 18 | 4425–4443 |
| 118. | Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Second Set of Requests for Production on Order Shortening Time and | 08/09/21 | 18 | 4444–4464 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Overruling Objection | | | |
| 119. | Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order | 08/10/21 | 18 | 4465–4486 |
| 120. | Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified | 08/11/21 | 18 | 4487–4497 |
| 121. | Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only) | 08/17/21 | 18<br>19 | 4498–4500<br>4501–4527 |
| 122. | Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order | 08/24/21 | 19 | 4528–4609 |
| 123. | Recorder's Transcript of Proceedings Re: Motions Hearing | 09/02/21 | 19 | 4610–4633 |
| 124. | Reply Brief on "Motion for Order to Show Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order" | 09/08/21 | 19 | 4634–4666 |
| 125. | Recorder's Partial Transcript of Proceedings Re: Motions Hearing | 09/09/21 | 19 | 4667–4680 |
| 126. | Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans) | 09/15/21 | 19 | 4681–4708 |
| 127. | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection | 09/16/21 | 19 | 4709–4726 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 128. | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection | 09/16/21 | 19 | 4727–4747 |
| 129. | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection | 09/16/21 | 19<br>20 | 4748–4750<br>4751–4769 |
| 130. | Defendants' Motion for Partial Summary Judgment | 09/21/21 | 20 | 4770–4804 |
| 131. | Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations | 09/21/21 | 20 | 4805–4829 |
| 132. | Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations | 09/21/21 | 20 | 4830–4852 |
| 133. | Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied | 09/21/21 | 20 | 4853–4868 |
| 134. | Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9) | 09/21/21 | 20 | 4869–4885 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 135. | Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims | 09/21/21 | 20 | 4886–4918 |
| 136. | Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs | 09/21/21 | 20 | 4919–4940 |
| 137. | Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 09/21/21 | 20 | 4941–4972 |
| 138. | Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided | 09/22/21 | 20<br>21 | 4973–5000<br>5001–5030 |
| 139. | Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided | 09/22/21 | 21 | 5031–5054 |
| 140. | Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of Plaintiffs Organizational, Management, and Ownership Structure, Including Flow of Funds Between Related Entities, Operating Companies, Parent Companies, and Subsidiaries | 09/22/21 | 21 | 5055–5080 |
| 141. | Defendants' Opposition to Plaintiffs' Motion | 09/29/21 | 21 | 5081–5103 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges | | | |
| 142. | Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time | 09/29/21 | 21 | 5104–5114 |
| 143. | Plaintiffs' Opposition to Defendants' Motion in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges | 09/29/21 | 21 | 5115–5154 |
| 144. | Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 09/29/21 | 21 | 5155–5169 |
| 145. | Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time | 10/04/21 | 21 | 5170–5201 |
| 146. | Transcript of Proceedings Re: Motions (Via Blue Jeans) | 10/06/21 | 21 | 5202–5234 |
| 147. | Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time | 10/07/21 | 21 | 5235–5245 |
| 148. | Second Amended Complaint | 10/07/21 | 21<br>22 | 5246–5250<br>5251–5264 |
| 149. | Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument Regarding the Fact that Plaintiffs Have | 10/08/21 | 22 | 5265–5279 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Dismissed Certain Claims and Parties on Order Shortening Time | | | |
| 150. | Defendants' Answer to Plaintiffs' Second Amended Complaint | 10/08/21 | 22 | 5280–5287 |
| 151. | Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures | 10/08/21 | 22 | 5288–5294 |
| 152. | Plaintiffs' Objections to Defendants' Pretrial Disclosures | 10/08/21 | 22 | 5295–5300 |
| 153. | Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time | 10/12/21 | 22 | 5301–5308 |
| 154. | Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order | 10/14/21 | 22 | 5309–5322 |
| 155. | Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 10/18/21 | 22 | 5323–5333 |
| 156. | Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline) | 10/18/21 | 22 | 5334–5338 |
| 157. | Transcript of Proceedings Re: Motions | 10/19/21 | 22<br>23 | 5339–5500<br>5501–5561 |
| 158. | Amended Transcript of Proceedings Re: Motions | 10/19/21 | 23<br>24 | 5562–5750<br>5751–5784 |
| 159. | Amended Transcript of Proceedings Re: Motions | 10/20/21 | 24 | 5785–5907 |
| 160. | Transcript of Proceedings Re: Motions | 10/22/21 | 24 | 5908–6000 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | | | 25 | 6001–6115 |
| 161. | Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment | 10/25/21 | 25 | 6116–6126 |
| 162. | Recorder's Transcript of Jury Trial – Day 1 | 10/25/21 | 25<br>26 | 6127–6250<br>6251–6279 |
| 163. | Recorder's Transcript of Jury Trial – Day 2 | 10/26/21 | 26 | 6280–6485 |
| 164. | Joint Pretrial Memorandum Pursuant to EDRC 2.67 | 10/27/21 | 26<br>27 | 6486–6500<br>6501–6567 |
| 165. | Recorder's Transcript of Jury Trial – Day 3 | 10/27/21 | 27<br>28 | 6568–6750<br>6751–6774 |
| 166. | Recorder's Transcript of Jury Trial – Day 4 | 10/28/21 | 28 | 6775–6991 |
| 167. | Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC) | 10/28/21 | 28<br>28 | 6992–6997 |
| 168. | Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC) | 10/28/21 | 28<br>29 | 6998–7000<br>7001–7003 |
| 169. | Defendants' Objection to Media Requests | 10/28/21 | 29 | 7004–7018 |
| 170. | Supplement to Defendants' Objection to Media Requests | 10/31/21 | 29 | 7019–7039 |
| 171. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations | 11/01/21 | 29 | 7040–7051 |
| 172. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence | 11/01/21 | 29 | 7052–7063 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Relating to Defendants' Agreements with Other Market Players and Related Negotiations | | | |
| 173. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges | 11/01/21 | 29 | 7064–7075 |
| 174. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied | 11/01/21 | 29 | 7076–7087 |
| 175. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement | 11/01/21 | 29 | 7088–7099 |
| 176. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6] | 11/01/21 | 29 | 7100–7111 |
| 177. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided | 11/01/21 | 29 | 7112–7123 |
| 178. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the | 11/01/21 | 29 | 7124–7135 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided | | | |
| 179. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9) | 11/01/21 | 29 | 7136–7147 |
| 180. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement | 11/01/21 | 29 | 7148–7159 |
| 181. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims | 11/01/21 | 29 | 7160–7171 |
| 182. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs | 11/01/21 | 29 | 7172–7183 |
| 183. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony | 11/01/21 | 29 | 7184–7195 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Regarding the TeamHealth Plaintiffs Policy not to Balance Bill | | | |
| 184. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D. | 11/01/21 | 29 | 7196–7207 |
| 185. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts | 11/01/21 | 29 | 7208–7219 |
| 186. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 11/01/21 | 29 | 7220–7231 |
| 187. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments | 11/01/21 | 29 | 7232–7243 |
| 188. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight | 11/01/21 | 29<br>30 | 7244–7250<br>7251–7255 |
| 189. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020 | 11/01/21 | 30 | 7256–7267 |
| 190. | Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained | 11/01/21 | 30 | 7268–7279 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Expert Robert Frantz, M.D. | | | |
| 191. | Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services | 11/01/21 | 30 | 7280–7291 |
| 192. | Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims | 11/01/21 | 30 | 7292–7354 |
| 193. | Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers | 11/01/21 | 30 | 7355–7366 |
| 194. | Plaintiffs' Notice of Amended Exhibit List | 11/01/21 | 30 | 7367–7392 |
| 195. | Plaintiffs' Response to Defendants' Objection to Media Requests | 11/01/21 | 30 | 7393–7403 |
| 196. | Recorder's Transcript of Jury Trial – Day 5 | 11/01/21 | 30<br>31 | 7404–7500<br>7501–7605 |
| 197. | Recorder's Transcript of Jury Trial – Day 6 | 11/02/21 | 31<br>32 | 7606–7750<br>7751–7777 |
| 198. | Defendants' Deposition Designations and Objections to Plaintiffs' Deposition Counter-Designations | 11/03/21 | 32 | 7778–7829 |
| 199. | Defendants' Objections to Plaintiffs' Proposed Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders | 11/03/21 | 32 | 7830–7852 |
| 200. | Notice of Entry of Order Affirming and | 11/03/21 | 32 | 7853–7874 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified | | | |
| 201. | Recorder's Transcript of Jury Trial – Day 7 | 11/03/21 | 32<br>33 | 7875–8000<br>8001–8091 |
| 202. | Notice of Entry of Order Granting Defendants' Motion in Limine No. 17 | 11/04/21 | 33 | 8092–8103 |
| 203. | Notice of Entry of Order Granting Defendants' Motion in Limine No. 25 | 11/04/21 | 33 | 8104–8115 |
| 204. | Notice of Entry of Order Granting Defendants' Motion in Limine No. 37 | 11/04/21 | 33 | 8116–8127 |
| 205. | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 9 | 11/04/21 | 33 | 8128–8140 |
| 206. | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 21 | 11/04/21 | 33 | 8141–8153 |
| 207. | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 22 | 11/04/21 | 33 | 8154–8165 |
| 208. | Plaintiffs' Notice of Deposition Designations | 11/04/21 | 33<br>34 | 8166–8250<br>8251–8342 |
| 209. | 1st Amended Jury List | 11/08/21 | 34 | 8343 |
| 210. | Recorder's Transcript of Jury Trial – Day 8 | 11/08/21 | 34<br>35 | 8344–8500<br>8501–8514 |
| 211. | Recorder's Amended Transcript of Jury Trial – Day 9 | 11/09/21 | 35 | 8515–8723 |
| 212. | Recorder's Transcript of Jury Trial – Day 9 | 11/09/21 | 35<br>36 | 8724–8750<br>8751–8932 |
| 213. | Recorder's Transcript of Jury Trial – Day 10 | 11/10/21 | 36 | 8933–9000 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | | | 37 | 9001–9152 |
| 214. | Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal | 11/12/21 | 37 | 9153–9161 |
| 215. | Notice of Entry of Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders | 11/12/21 | 37 | 9162–9173 |
| 216. | Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies | 11/12/21 | 37 | 9174–9184 |
| 217. | Recorder's Transcript of Jury Trial – Day 11 | 11/12/21 | 37<br>38 | 9185–9250<br>9251–9416 |
| 218. | Plaintiffs' Trial Brief Regarding Specific Price Term | 11/14/21 | 38 | 9417–9425 |
| 219. | 2nd Amended Jury List | 11/15/21 | 38 | 9426 |
| 220. | Defendants' Proposed Jury Instructions (Contested) | 11/15/21 | 38 | 9427–9470 |
| 221. | Jointly Submitted Jury Instructions | 11/15/21 | 38 | 9471–9495 |
| 222. | Plaintiffs' Proposed Jury Instructions (Contested) | 11/15/21 | 38<br>39 | 9496–9500<br>9501–9513 |
| 223. | Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim | 11/15/21 | 39 | 9514–9521 |
| 224. | Recorder's Transcript of Jury Trial – Day 12 | 11/15/21 | 39<br>40 | 9522–9750<br>9751–9798 |
| 225. | Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative | 11/16/21 | 40 | 9799–9806 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Remedies | | | |
| 226. | General Defense Verdict | 11/16/21 | 40 | 9807–9809 |
| 227. | Plaintiffs' Proposed Verdict Form | 11/16/21 | 40 | 9810–9819 |
| 228. | Recorder's Transcript of Jury Trial – Day 13 | 11/16/21 | 40<br>41 | 9820–10,000<br>10,001–10,115 |
| 229. | Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties | 11/16/21 | 41 | 10,116–10,152 |
| 230. | Response to Plaintiffs' Trial Brief Regarding Specific Price Term | 11/16/21 | 41 | 10,153–10,169 |
| 231. | Special Verdict Form | 11/16/21 | 41 | 10,169–10,197 |
| 232. | Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract | 11/16/21 | 41 | 10,198–10,231 |
| 233. | Trial Brief Regarding Jury Instructions on Unjust Enrichment | 11/16/21 | 41 | 10,232–10,248 |
| 234. | 3rd Amended Jury List | 11/17/21 | 41 | 10,249 |
| 235. | Defendants' Motion for Judgment as a Matter of Law | 11/17/21 | 41<br>42 | 10,250<br>10,251–10,307 |
| 236. | Plaintiffs' Supplemental Jury Instruction (Contested) | 11/17/21 | 42 | 10,308–10,313 |
| 237. | Recorder's Transcript of Jury Trial – Day 14 | 11/17/21 | 42<br>43 | 10,314–10,500<br>10,501–10,617 |
| 238. | Errata to Source on Defense Contested Jury Instructions | 11/18/21 | 43 | 10,618–10,623 |
| 239. | Recorder's Transcript of Jury Trial – Day 15 | 11/18/21 | 43<br>44 | 10,624–10,750<br>10,751–10,946 |
| 240. | Defendants' Supplemental Proposed Jury Instructions (Contested) | 11/19/21 | 44 | 10,947–10,952 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 241. | Errata | 11/19/21 | 44 | 10,953 |
| 242. | Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 11/19/21 | 44 | 10,954–10,963 |
| 243. | Plaintiffs' Proposed Special Verdict Form | 11/19/21 | 44 | 10,964–10,973 |
| 244. | Recorder's Transcript of Jury Trial – Day 16 | 11/19/21 | 44<br>45 | 10,974–11,000<br>11,001–11,241 |
| 245. | Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim | 11/19/21 | 45<br>46 | 11,242–11,250<br>11,251–11,254 |
| 246. | Plaintiffs' Second Supplemental Jury Instructions (Contested) | 11/20/21 | 46 | 11,255–11,261 |
| 247. | Defendants' Supplemental Proposed Jury Instruction | 11/21/21 | 46 | 11,262–11,266 |
| 248. | Plaintiffs' Third Supplemental Jury Instructions (Contested) | 11/21/21 | 46 | 11,267–11,272 |
| 249. | Recorder's Transcript of Jury Trial – Day 17 | 11/22/21 | 46<br>47 | 11,273–11,500<br>11.501–11,593 |
| 250. | Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 11/22/21 | 47 | 11,594–11,608 |
| 251. | Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 11/22/21 | 47 | 11,609–11,631 |
| 252. | 4th Amended Jury List | 11/23/21 | 47 | 11,632 |
| 253. | Recorder's Transcript of Jury Trial – Day 18 | 11/23/21 | 47<br>48 | 11,633–11,750<br>11,751–11,907 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 254. | Recorder's Transcript of Jury Trial – Day 19 | 11/24/21 | 48 | 11,908–11,956 |
| 255. | Jury Instructions | 11/29/21 | 48 | 11,957–11,999 |
| 256. | Recorder's Transcript of Jury Trial – Day 20 | 11/29/21 | 48<br>49 | 12,000<br>12,001–12,034 |
| 257. | Special Verdict Form | 11/29/21 | 49 | 12,035–12,046 |
| 258. | Verdict(s) Submitted to Jury but Returned Unsigned | 11/29/21 | 49 | 12,047–12,048 |
| 259. | Defendants' Proposed Second Phase Jury Instructions | 12/05/21 | 49 | 12,049–12,063 |
| 260. | Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form | 12/06/21 | 49 | 12,064–12,072 |
| 261. | Plaintiffs' Supplement to Proposed Second Phase Jury Instructions | 12/06/21 | 49 | 12,072–12,077 |
| 262. | Recorder's Transcript of Jury Trial – Day 21 | 12/06/21 | 49 | 12,078–,12,135 |
| 263. | Defendants' Proposed Second Phase Jury Instructions-Supplement | 12/07/21 | 49 | 12,136–12,142 |
| 264. | Jury Instructions Phase Two | 12/07/21 | 49 | 12,143–12,149 |
| 265. | Special Verdict Form | 12/07/21 | 49 | 12,150–12,152 |
| 266. | Recorder's Transcript of Jury Trial – Day 22 | 12/07/21 | 49<br>50 | 12,153–12,250<br>12,251–12,293 |
| 267. | Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits | 12/15/21 | 50 | 12,294–12,302 |
| 268. | Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits | 12/15/21 | 50 | 12,303–12,311 |
| 269. | Notice of Entry of Order Granting Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at | 12/27/21 | 50 | 12,312–12,322 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Trial Under Seal | | | |
| 270. | Plaintiffs' Opposition to United's Motion to Seal | 12/29/21 | 50 | 12,323–12,341 |
| 271. | Defendants' Motion to Apply the Statutory Cap on Punitive Damages | 12/30/21 | 50 | 12,342–12,363 |
| 272. | Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage | 12/30/21 | 50<br>51 | 12,364–12,500<br>12,501–12,706 |
| 273. | Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law | 01/04/22 | 51 | 12,707–12,717 |
| 274. | Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law | 01/06/22 | 51 | 12,718–12,738 |
| 275. | Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits | 01/10/22 | 51 | 12,739–12,747 |
| 276. | Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits | 01/10/22 | 51<br>52 | 12,748–12,750<br>12,751–12,756 |
| 277. | Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing on Defendants' Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time | 01/11/22 | 52 | 12,757–12,768 |
| 278. | Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing | 01/12/22 | 52 | 12,769–12,772 |
| 279. | Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for | 01/20/22 | 52 | 12,773–12,790 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Entry of Judgment | | | |
| 280. | Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment | 01/20/22 | 52 | 12,791–12,968 |
| 281. | Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions | 01/31/22 | 52 | 12,969–12,979 |
| 282. | Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions | 02/08/22 | 52 | 12,980–12,996 |
| 283. | Defendants' Opposition to Plaintiffs' Cross-Motion for Entry of Judgment | 02/10/22 | 52<br>53 | 12,997–13,000<br>13,001–13,004 |
| 284. | Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages | 02/10/22 | 53 | 13,005–13,028 |
| 285. | Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits | 02/14/22 | 53 | 13,029–13,046 |
| 286. | Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time | 02/15/22 | 53 | 13,047–13,053 |
| 287. | Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment | 02/15/22 | 53 | 13,054–13,062 |
| 288. | Defendants' Index of Trial Exhibit Redactions in Dispute | 02/16/22 | 53 | 13,063–13,073 |
| 289. | Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits | 02/17/22 | 53 | 13,074–13,097 |
| 290. | Transcript of Proceedings Re: Motions Hearing | 02/17/22 | 53 | 13,098–13,160 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 291. | Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages | 03/04/22 | 53 | 13,161–13,167 |
| 292. | Notice of Entry of Judgment | 03/09/22 | 53 | 13,168–13,178 |
| 293. | Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages | 03/09/22 | 53 | 13,179–13,197 |
| 294. | Health Care Providers' Verified Memorandum of Cost | 03/14/22 | 53 | 13,198–13,208 |
| 295. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1 | 03/14/22 | 53<br>54 | 13,209–13,250<br>13.251–13,464 |
| 296. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2 | 03/14/22 | 54<br>55 | 13,465–13,500<br>13,501–13,719 |
| 297. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3 | 03/14/22 | 55<br>56 | 13,720–13,750<br>13,751–13,976 |
| 298. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4 | 03/14/22 | 56<br>57 | 13,977–14,000<br>14,001–14,186 |
| 299. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5 | 03/14/22 | 57<br>58 | 14,187–14,250<br>14,251–14,421 |
| 300. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6 | 03/14/22 | 58<br>59 | 14,422–14,500<br>14,501–14,673 |
| 301. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7 | 03/14/22 | 59<br>60 | 14,674–14,750<br>14,751–14,920 |
| 302. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of | 03/14/22 | 60<br>61 | 14,921–15,000<br>15,001–15,174 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Cost Volume 8 | | | |
| 303. | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 9 | 03/14/22 | 61<br>62 | 15,175–15,250<br>15,251–15,373 |
| 304. | Defendants' Motion to Retax Costs | 03/21/22 | 62 | 15,374–15,388 |
| 305. | Health Care Providers' Motion for Attorneys' Fees | 03/30/22 | 62 | 15,389–15,397 |
| 306. | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1 | 03/30/22 | 62<br>63 | 15,398–15,500<br>15,501–15,619 |
| 307. | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2 | 03/30/22 | 63<br>64 | 15,620–15,750<br>15,751–15,821 |
| 308. | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 3 | 03/30/22 | 64<br>65 | 15,822–16,000<br>16,001–16,053 |
| 309. | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4 | 03/30/22 | 65 | 16,054–16,232 |
| 310. | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5 | 03/30/22 | 65<br>66 | 16,233–16,250<br>16,251–16,361 |
| 311. | Defendants Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions on Order Shortening Time | 04/05/22 | 66 | 16,362–16,381 |
| 312. | Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 04/06/22 | 66 | 16,382–16,399 |
| 313. | Defendants' Renewed Motion for Judgment as a Matter of Law | 04/06/22 | 66 | 16,400–16,448 |
| 314. | Motion for New Trial | 04/06/22 | 66<br>67 | 16,449–16,500<br>16,501–16,677 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 315. | Notice of Appeal | 04/06/22 | 67 | 16,678–16,694 |
| 316. | Case Appeal Statement | 04/06/22 | 67<br>68 | 16,695–16,750<br>16,751–16,825 |
| 317. | Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay | 04/07/22 | 68 | 16,826–16,831 |
| 318. | Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*) | 04/07/22 | 68 | 16,832–16,836 |
| 319. | Transcript of Proceedings Re: Motions Hearing | 04/07/22 | 68 | 16,837–16,855 |
| 320. | Opposition to Defendants' Motion to Retax Costs | 04/13/22 | 68 | 16,856–16,864 |
| 321. | Appendix in Support of Opposition to Defendants' Motion to Retax Costs | 04/13/22 | 68<br>69 | 16,865–17,000<br>17,001–17,035 |
| 322. | Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees | 04/20/22 | 69 | 17,036–17,101 |
| 323. | Transcript of Proceedings Re: Motions Hearing | 04/21/22 | 69 | 17,102–17,113 |
| 324. | Notice of Posting *Supersedeas* Bond | 04/29/22 | 69 | 17,114–17,121 |
| 325. | Defendants' Reply in Support of Motion to Retax Costs | 05/04/22 | 69 | 17,122–17,150 |
| 326. | Health Care Providers' Reply in Support of Motion for Attorneys' Fees | 05/04/22 | 69 | 17,151–17,164 |
| 327. | Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 05/04/22 | 69 | 17,165–17,178 |
| 328. | Plaintiffs' Opposition to Defendants' Motion for New Trial | 05/04/22 | 69<br>70 | 17,179–17,250<br>17,251–17,335 |
| 329. | Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter | 05/05/22 | 70 | 17,336–17,373 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | of Law | | | |
| 330. | Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 06/22/22 | 70 | 17,374–17,385 |
| 331. | Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law | 06/22/22 | 70 | 17,386–17,411 |
| 332. | Reply in Support of Motion for New Trial | 06/22/22 | 70 | 17,412–17,469 |
| 333. | Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees | 06/24/22 | 70<br>71 | 17,470–17,500<br>17,501–17,578 |
| 334. | Defendants' Response to Improper Supplement Entitled "Notice of Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees" | 06/28/22 | 71 | 17,579–17,593 |
| 335. | Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 06/29/22 | 71 | 17,594–17,609 |
| 336. | Transcript of Proceedings Re: Motions Hearing | 06/29/22 | 71 | 17,610–17,681 |
| 337. | Order Amending Oral Ruling Granting Defendants' Motion to Retax | 07/01/22 | 71 | 17,682–17,688 |
| 338. | Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 07/19/22 | 71 | 17,689–17,699 |
| 339. | Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees | 07/26/22 | 71 | 17,700–17,706 |
| 340. | Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees | 08/02/22 | 71 | 17,707–17,725 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 341. | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Retax Costs | 08/02/22 | 71 | 17,726–17,739 |
| 342. | Amended Case Appeal Statement | 08/15/22 | 71<br>72 | 17,740–17,750<br>17,751–17,803 |
| 343. | Amended Notice of Appeal | 08/15/22 | 72 | 17,804–17,934 |
| 344. | Reply in Support of Supplemental Attorney's Fees Request | 08/22/22 | 72 | 17,935–17,940 |
| 345. | Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial | 09/13/22 | 72 | 17,941–17,950 |
| 346. | Recorder's Transcript of Hearing Re: Hearing | 09/22/22 | 72 | 17,951–17,972 |
| 347. | Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket" | 10/06/22 | 72 | 17,973–17,978 |
| 348. | Defendants' Motion to Redact Portions of Trial Transcript | 10/06/22 | 72 | 17,979–17,989 |
| 349. | Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript | 10/07/22 | 72 | 17,990–17,993 |
| 350. | Transcript of Proceedings re Status Check | 10/10/22 | 72<br>73 | 17,994–18,000<br>18,001–18,004 |
| 351. | Notice of Entry of Order Approving Supplemental Attorney's Fee Award | 10/12/22 | 73 | 18,005–18,015 |
| 352. | Notice of Entry of Order Denying Defendants' Motion for New Trial | 10/12/22 | 73 | 18,016–18,086 |
| 353. | Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law | 10/12/22 | 73 | 18,087–18,114 |
| 354. | Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to | 10/12/22 | 73 | 18,115–18,125 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Docket | | | |
| 355. | Notice of Appeal | 10/12/22 | 73<br>74 | 18,126–18,250<br>18,251–18,467 |
| 356. | Case Appeal Statement | 10/12/22 | 74<br>75 | 18,468–18,500<br>18,501–18,598 |
| 357. | Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript" | 10/13/22 | 75 | 18,599–18,608 |
| 358. | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits | 10/18/22 | 75<br>76 | 18,609–18,750<br>18,751–18,755 |
| 359. | Recorder's Transcript of Hearing Status Check | 10/20/22 | 76 | 18,756–18,758 |
| 360. | Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts | 10/25/22 | 76 | 18,759–18,769 |
| 361. | Notice of Filing of Writ Petition | 11/17/22 | 76 | 18,770–18855 |
| 362. | Trial Exhibit D5502 | | 76<br>77 | 18,856–19,000<br>19,001–19,143 |
| 491. | Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 03/08/21 | 145<br>146 | 35,813–36,062<br>36,063–36,085 |
| 492. | Transcript Re: Proposed Jury Instructions | 11/21/21 | 146 | 36,086–36,250 |

***Filed Under Seal***

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 363. | Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 09/28/20 | 78 | 19,144–19,156 |

| | | | | |
|---|---|---|---|---|
| 364. | Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 04/01/21 | 78 | 19,157–19,176 |
| 365. | Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 04/01/21 | 78 | 19,177–19,388 |
| 366. | Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order | 04/19/21 | 78<br>79 | 19,389–19,393<br>19,394–19,532 |
| 367. | Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time | 05/05/21 | 79 | 19,533–19,581 |
| 368. | Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time | 05/21/21 | 79<br>80<br>81 | 19,582–19,643<br>19,644–19,893<br>19,894–20,065 |
| 369. | Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time | 06/01/21 | 81<br>82 | 20,066–20,143<br>20,144–20,151 |
| 370. | Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality | 06/01/21 | 82 | 20,152–20,211 |

| | | | | |
|---|---|---|---|---|
| | Designations (Filed April 15, 2021) | | | |
| 371. | Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions | 06/16/21 | 82 | 20,212–20,265 |
| 372. | United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time | 06/24/21 | 82 | 20,266–20,290 |
| 373. | Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time | 06/24/21 | 82<br>83<br>84 | 20,291–20,393<br>20,394–20,643<br>20,644–20,698 |
| 374. | Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time | 07/06/21 | 84 | 20,699–20,742 |
| 375. | Defendants' Motion for Leave to File Defendants' Objection to the Special Master's Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Under Seal | 07/15/21 | 84 | 20,743–20,750 |
| 376. | Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions | 07/22/21 | 84 | 20,751–20,863 |
| 377. | Objection to R&R #11 Regarding United's Motion to Compel Documents About Which Plaintiffs' Witnesses Testified | 08/25/21 | 84<br>85 | 20,864–20,893<br>20,894–20,898 |

| | | | | |
|---|---|---|---|---|
| 378. | Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders | 09/21/21 | 85 | 20,899–20,916 |
| 379. | Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders | 09/21/21 | 85 | 20,917–21,076 |
| 380. | Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges | 09/21/21 | 85 | 21,077–21,089 |
| 381. | Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges | 09/21/21 | 85<br>86 | 21,090–21,143<br>21,144–21,259 |
| 382. | Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges | 09/21/21 | 86 | 21,260–21,313 |
| 383. | Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6] | 09/21/21 | 86 | 21,314–21,343 |
| 384. | Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable | 09/21/21 | 86 | 21,344–21,368 |
| 385. | Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6) | 09/21/21 | 86<br>87 | 21,369–21,393<br>21,394–21,484 |

| | | | | |
|---|---|---|---|---|
| 386. | Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6) | 09/21/21 | 87 | 21,485–21,614 |
| 387. | Appendix to Defendants' Motion in Limine No. 13 (Volume 3 of 6) | 09/21/21 | 87<br>88 | 21,615–21,643<br>21,644–21,744 |
| 388. | Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6) | 09/21/21 | 88 | 21,745–21,874 |
| 389. | Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6) | 09/21/21 | 88<br>89 | 21,875–21,893<br>21,894–22,004 |
| 390. | Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6) | 09/21/21 | 89 | 22,005–22,035 |
| 391. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8 | 09/21/21 | 89<br>90 | 22,036–22,143<br>22,144–22,176 |
| 392. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8 | 09/21/21 | 90 | 22,177–22,309 |
| 393. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8 | 09/22/21 | 90<br>91 | 22,310–22,393<br>22,394–22,442 |
| 394. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8 | 09/22/21 | 91 | 22,443–22,575 |
| 395. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8 | 09/22/21 | 91 | 22,576–22,609 |
| 396. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8 | 09/22/21 | 91<br>92<br>93 | 22,610–22,643<br>22,644–22,893<br>22,894–23,037 |
| 397. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8 | 09/22/21 | 93<br>94 | 23,038–23,143<br>23,144–23,174 |
| 398. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8 | 09/22/21 | 94 | 23,175–23,260 |
| 399. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8 | 09/22/21 | 94<br>95 | 23,261–23,393<br>23,394–23,535 |
| 400. | Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8 | 09/22/21 | 95<br>96 | 23,536–23,643<br>23,634–23,801 |
| 401. | Defendants' Motion in Limine No. 11 Paired | 09/22/21 | 96 | 23,802–23,823 |

| | | | | |
|---|---|---|---|---|
| | with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement | | | |
| 402. | Errata to Defendants' Motion in Limine No. 11 | 09/22/21 | 96 | 23,824–23,859 |
| 403. | Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement | 09/22/21 | 96 | 23,860–23,879 |
| 404. | Errata to Defendants' Motion in Limine No. 12 | 09/22/21 | 96<br>97 | 23,880–23,893<br>23,894–23,897 |
| 405. | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1) | 09/22/21 | 97 | 23,898–24,080 |
| 406. | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2) | 09/22/21 | 97<br>98 | 24,081–24,143<br>24,144–24,310 |
| 407. | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3) | 09/22/21 | 98<br>99<br>100 | 24,311–24,393<br>24,394–24,643<br>24,644–24,673 |
| 408. | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4) | 09/22/21 | 100<br>101<br>102 | 24,674–24,893<br>24,894–25,143<br>25,144–25,204 |
| 409. | Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6 | 09/22/21 | 102 | 25,205–25,226 |
| 410. | Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6 | 09/22/21 | 102 | 25,227–25,364 |
| 411. | Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6 | 09/22/21 | 102<br>103 | 25,365–25,393<br>25,394–25,494 |
| 412. | Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6 | 09/22/21 | 103 | 25,495–25,624 |
| 413. | Appendix to Defendants' Motion in Limine | 09/22/21 | 103 | 25,625–25,643 |

| | | | | |
|---|---|---|---|---|
| | No. 14 – Volume 5 of 6 | | 104 | 25,644–25,754 |
| 414. | Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6 | 09/22/21 | 104 | 25,755–25,785 |
| 415. | Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13 | 09/29/21 | 104 | 25,786–25,850 |
| 416. | Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14 | 09/29/21 | 104 | 25,851–25,868 |
| 417. | Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders | 09/29/21 | 104<br>105 | 25,869–25,893<br>25,894–25,901 |
| 418. | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1 | 09/29/21 | 105<br>106 | 25,902–26,143<br>26,144–26,216 |
| 419. | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2 | 09/29/21 | 106<br>107 | 26,217–26,393<br>26,394–26,497 |
| 420. | Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment | 10/05/21 | 107 | 26,498–26,605 |
| 421. | Defendants' Reply in Support of Motion for Partial Summary Judgment | 10/11/21 | 107<br>108 | 26,606–26,643<br>26,644–26,663 |
| 422. | Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 10/17/21 | 108 | 26,664–26,673 |
| 423. | Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for | 10/17/21 | 108<br>109 | 26,674–26,893<br>26,894–26,930 |

| | | | | |
|---|---|---|---|---|
| | Partial Summary Judgment | | | |
| 424. | Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 10/21/21 | 109 | 26,931–26,952 |
| 425. | Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties | 10/31/21 | 109 | 26,953–26,964 |
| 426. | Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties | 11/08/21 | 109 | 26,965–26,997 |
| 427. | Excerpts of Recorder's Transcript of Jury Trial – Day 9 | 11/09/21 | 109 | 26,998–27003 |
| 428. | Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial | 11/11/21 | 109 | 27,004–27,055 |
| 429. | Appendix of Selected Exhibits to Trial Briefs | 11/16/21 | 109 | 27,056–27,092 |
| 430. | Excerpts of Recorder's Transcript of Jury Trial – Day 13 | 11/16/21 | 109 | 27,093–27,099 |
| 431. | Defendants' Omnibus Offer of Proof | 11/22/21 | 109<br>110 | 27,100–27,143<br>27,144–27,287 |
| 432. | Motion to Seal Certain Confidential Trial Exhibits | 12/05/21 | 110 | 27,288–27,382 |
| 433. | Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits | 12/08/21 | 110<br>111 | 27,383–27,393<br>27,394–27,400 |
| 434. | Motion to Seal Certain Confidential Trial Exhibits | 12/13/21 | 111 | 27,401–27,495 |
| 435. | Defendant's Omnibus Offer of Proof for Second Phase of Trial | 12/14/21 | 111 | 27,496–27,505 |

| | | | | |
|---|---|---|---|---|
| 436. | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1 | 12/14/21 | 111<br>112 | 27,506–27,643<br>27,644–27,767 |
| 437. | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2 | 12/14/21 | 112<br>113 | 27,768–27,893<br>27,894–27,981 |
| 438. | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3 | 12/14/21 | 113<br>114 | 27,982–28,143<br>28,144–28,188 |
| 439. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18 | 12/24/21 | 114 | 28,189–28,290 |
| 440. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18 | 12/24/21 | 114<br>115 | 28,291–28,393<br>28,394–28,484 |
| 441. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 | 12/24/21 | 115<br>116 | 28,485–28,643<br>28,644–28,742 |
| 442. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 | 12/24/21 | 116<br>117 | 28,743–28,893<br>28,894–28,938 |
| 443. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 | 12/24/21 | 117 | 28,939–29,084 |
| 444. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 | 12/24/21 | 117<br>118 | 29,085–29,143<br>29,144–29,219 |
| 445. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18 | 12/24/21 | 118 | 29,220–29,384 |
| 446. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18 | 12/24/21 | 118<br>119 | 29,385–29,393<br>29,394–29,527 |

| | | | | |
|---|---|---|---|---|
| 447. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 | 12/24/21 | 119<br>120 | 29,528–29,643<br>29,644–29,727 |
| 448. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 10 of 18 | 12/24/21 | 120<br>121 | 29,728–29,893<br>29,894–29,907 |
| 449. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18 | 12/24/21 | 121 | 29,908–30,051 |
| 450. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 | 12/24/21 | 121<br>122 | 30,052–30,143<br>30,144–30,297 |
| 451. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 | 12/24/21 | 122<br>123 | 30,298–30,393<br>30,394–30,516 |
| 452. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 | 12/24/21 | 123<br>124 | 30,517–30,643<br>30,644–30,677 |
| 453. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 | 12/24/21 | 124 | 30,678–30,835 |
| 454. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 | 12/24/21 | 124<br>125 | 30,836–30,893<br>30,894–30,952 |
| 455. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 | 12/24/21 | 125 | 30,953–31,122 |
| 456. | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 | 12/24/21 | 125<br>126 | 30,123–31,143<br>31,144–31,258 |
| 457. | Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits | 01/05/22 | 126 | 31,259–31,308 |
| 458. | Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial | 01/05/22 | 126 | 31,309–31,393 |

| | | | | |
|---|---|---|---|---|
| | Exhibits | | 127 | 31,394–31,500 |
| 459. | Transcript of Proceedings Re: Motions | 01/12/22 | 127 | 31,501–31,596 |
| 460. | Transcript of Proceedings Re: Motions | 01/20/22 | 127<br>128 | 31,597–31,643<br>31,644–31,650 |
| 461. | Transcript of Proceedings Re: Motions | 01/27/22 | 128 | 31,651–31,661 |
| 462. | Defendants' Index of Trial Exhibit Redactions in Dispute | 02/10/22 | 128 | 31,662–31,672 |
| 463. | Transcript of Proceedings Re: Motions Hearing | 02/10/22 | 128 | 31,673–31,793 |
| 464. | Transcript of Proceedings Re: Motions Hearing | 02/16/22 | 128 | 31,794–31,887 |
| 465. | Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in Dispute | 03/04/22 | 128<br>129 | 31,888–31,893<br>31,894–31,922 |
| 466. | Transcript of Proceedings re Hearing Regarding Unsealing Record | 10/05/22 | 129 | 31,923–31,943 |
| 467. | Transcript of Proceedings re Status Check | 10/06/22 | 129 | 31,944–31,953 |
| 468. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1) | 10/07/22 | 129<br>130 | 31,954–32,143<br>32,144–32,207 |
| 469. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2) | 10/07/22 | 130<br>131 | 32,208–32,393<br>32,394–32,476 |
| 470. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3) | 10/07/22 | 131<br>132 | 32,477–32,643<br>32,644–32,751 |
| 471. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume | 10/07/22 | 132<br>133 | 32,752–32,893<br>32,894–33,016 |

| | | | | |
|---|---|---|---|---|
| | 4) | | | |
| 472. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5) | 10/07/22 | 133<br>134 | 33,017–33,143<br>33,144–33,301 |
| 473. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6) | 10/07/22 | 134<br>135 | 33,302–33,393<br>33,394–33,529 |
| 474. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7) | 10/07/22 | 135<br>136 | 33,530–33,643<br>33,644–33,840 |
| 475. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8) | 10/07/22 | 136<br>137 | 33,841–33,893<br>33,894–34,109 |
| 476. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9) | 10/07/22 | 137<br>138 | 34,110–34,143<br>34,144–34,377 |
| 477. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10) | 10/07/22 | 138<br>139<br>140 | 34,378–34,393<br>34,394–34,643<br>34,644–34,668 |
| 478. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11) | 10/07/22 | 140<br>141 | 34,669–34,893<br>34,894–34,907 |
| 479. | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12) | 10/07/22 | 141<br>142 | 34,908–35,143<br>35,144–35,162 |
| 480. | Appendix B to Order Granting in Part and | 10/07/22 | 142 | 35,163–35,242 |

| | | | | |
|---|---|---|---|---|
| | Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13) | | | |
| 481. | Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119) | 10/07/22 | 142 | 35,243–35,247 |
| 482. | Transcript of Status Check | 10/10/22 | 142 | 35,248–35,258 |
| 483. | Recorder's Transcript of Hearing re Hearing | 10/13/22 | 142 | 35,259–35,263 |
| 484. | Trial Exhibit D5499 | | 142<br>143 | 35,264–35,393<br>35,394–35,445 |
| 485. | Trial Exhibit D5506 | | 143 | 35,446 |
| 486. | Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 09/28/20 | 143 | 35,447–35,634 |
| 487. | Defendants' Motion to Supplement Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time | 05/24/21 | 143<br>144 | 35,635–35,643<br>35,644–35,648 |
| 488. | Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges | 09/21/21 | 144 | 35,649–35,702 |
| 489. | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43) | 09/29/21 | 144 | 35,703–35,713 |
| 490. | Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021 | 04/18/23 | 144 | 35,714–35,812 |

## ALPHABETICAL TABLE OF CONTENTS TO APPENDIX


| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 209 | 1st Amended Jury List | 11/08/21 | 34 | 8343 |
| 219 | 2nd Amended Jury List | 11/15/21 | 38 | 9426 |
| 234 | 3rd Amended Jury List | 11/17/21 | 41 | 10,249 |
| 252 | 4th Amended Jury List | 11/23/21 | 47 | 11,632 |
| 342 | Amended Case Appeal Statement | 08/15/22 | 71<br>72 | 17,740–17,750<br>17,751–17,803 |
| 17 | Amended Motion to Remand | 01/15/20 | 2 | 310–348 |
| 343 | Amended Notice of Appeal | 08/15/22 | 72 | 17,804–17,934 |
| 117 | Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection | 08/09/21 | 18 | 4425–4443 |
| 118 | Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection | 08/09/21 | 18 | 4444–4464 |
| 158 | Amended Transcript of Proceedings Re: Motions | 10/19/21 | 23<br>24 | 5562–5750<br>5751–5784 |
| 159 | Amended Transcript of Proceedings Re: Motions | 10/20/21 | 24 | 5785–5907 |
| 47 | Amended Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement | 07/29/20 | 7 | 1664–1683 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 468 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1) (Filed Under Seal) | 10/07/22 | 129<br>130 | 31,954–32,143<br>32,144–32,207 |
| 469 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2) (Filed Under Seal) | 10/07/22 | 130<br>131 | 32,208–32,393<br>32,394–32,476 |
| 470 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3) (Filed Under Seal) | 10/07/22 | 131<br>132 | 32,477–32,643<br>32,644–32,751 |
| 471 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 4) (Filed Under Seal) | 10/07/22 | 132<br>133 | 32,752–32,893<br>32,894–33,016 |
| 472 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5) (Filed Under Seal) | 10/07/22 | 133<br>134 | 33,017–33,143<br>33,144–33,301 |
| 473 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6) (Filed Under Seal) | 10/07/22 | 134<br>135 | 33,302–33,393<br>33,394–33,529 |
| 474 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7) (Filed Under Seal) | 10/07/22 | 135<br>136 | 33,530–33,643<br>33,644–33,840 |
| 475 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8) (Filed Under Seal) | 10/07/22 | 136<br>137 | 33,841–33,893<br>33,894–34,109 |
| 476 | Appendix B to Order Granting in Part and | 10/07/22 | 137 | 34,110–34,143 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9) (Filed Under Seal) | | 138 | 34,144–34,377 |
| 477 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10) (Filed Under Seal) | 10/07/22 | 138<br>139<br>140 | 34,378–34,393<br>34,394–34,643<br>34,644–34,668 |
| 478 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11) (Filed Under Seal) | 10/07/22 | 140<br>141 | 34,669–34,893<br>34,894–34,907 |
| 479 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12) (Filed Under Seal) | 10/07/22 | 141<br>142 | 34,908–35,143<br>35,144–35,162 |
| 480 | Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13) (Filed Under Seal) | 10/07/22 | 142 | 35,163–35,242 |
| 321 | Appendix in Support of Opposition to Defendants' Motion to Retax Costs | 04/13/22 | 68<br>69 | 16,865–17,000<br>17,001–17,035 |
| 280 | Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment | 01/20/22 | 52 | 12,791–12,968 |
| 306 | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1 | 03/30/22 | 62<br>63 | 15,398–15,500<br>15,501–15,619 |
| 307 | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2 | 03/30/22 | 63<br>64 | 15,620–15,750<br>15,751–15,821 |
| 308 | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees | 03/30/22 | 64<br>65 | 15,822–16,000<br>16,001–16,053 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Volume 3 | | | |
| 309 | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4 | 03/30/22 | 65 | 16,054–16,232 |
| 310 | Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5 | 03/30/22 | 65<br>66 | 16,233–16,250<br>16,251–16,361 |
| 295 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1 | 03/14/22 | 53<br>54 | 13,209–13,250<br>13.251–13,464 |
| 296 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2 | 03/14/22 | 54<br>55 | 13,465–13,500<br>13,501–13,719 |
| 297 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3 | 03/14/22 | 55<br>56 | 13,720–13,750<br>13,751–13,976 |
| 298 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4 | 03/14/22 | 56<br>57 | 13,977–14,000<br>14,001–14,186 |
| 299 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5 | 03/14/22 | 57<br>58 | 14,187–14,250<br>14,251–14,421 |
| 300 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6 | 03/14/22 | 58<br>59 | 14,422–14,500<br>14,501–14,673 |
| 301 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7 | 03/14/22 | 59<br>60 | 14,674–14,750<br>14,751–14,920 |
| 302 | Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 8 | 03/14/22 | 60<br>61 | 14,921–15,000<br>15,001–15,174 |
| 303 | Appendix of Exhibits in Support of Health | 03/14/22 | 61 | 15,175–15,250 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Care Providers' Verified Memorandum of Cost Volume 9 | | 62 | 15,251–15,373 |
| 486 | Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal) | 09/28/20 | 143 | 35,447–35,634 |
| 423 | Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal) | 10/17/21 | 108<br>109 | 26,674–26,893<br>26,894–26,930 |
| 379 | Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal) | 09/21/21 | 85 | 20,917–21,076 |
| 381 | Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal) | 09/21/21 | 85<br>86 | 21,090–21,143<br>21,144–21,259 |
| 26 | Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss | 03/26/20 | 4 | 784–908 |
| 491 | Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 03/08/21 | 145<br>146 | 35,813–36,062<br>36,063–36,085 |
| 365 | Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to | 04/01/21 | 78 | 19,177–19,388 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal) | | | |
| 272 | Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage | 12/30/21 | 50<br>51 | 12,364–12,500<br>12,501–12,706 |
| 436 | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1 (Filed Under Seal) | 12/14/21 | 111<br>112 | 27,506–27,643<br>27,644–27,767 |
| 437 | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2 (Filed Under Seal) | 12/14/21 | 112<br>113 | 27,768–27,893<br>27,894–27,981 |
| 438 | Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3 (Filed Under Seal) | 12/14/21 | 113<br>114 | 27,982–28,143<br>28,144–28,188 |
| 429 | Appendix of Selected Exhibits to Trial Briefs (Filed Under Seal) | 11/16/21 | 109 | 27,056–27,092 |
| 405 | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1) (Filed Under Seal) | 09/22/21 | 97 | 23,898–24,080 |
| 406 | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2) (Filed Under Seal) | 09/22/21 | 97<br>98 | 24,081–24,143<br>24,144–24,310 |
| 407 | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3) (Filed Under Seal) | 09/22/21 | 98<br>99<br>100 | 24,311–24,393<br>24,394–24,643<br>24,644–24,673 |
| 408 | Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4) (Filed Under Seal) | 09/22/21 | 100<br>101<br>102 | 24,674–24,893<br>24,894–25,143<br>25,144–25,204 |
| 391 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8 (Filed Under Seal) | 09/21/21 | 89<br>90 | 22,036–22,143<br>22,144–22,176 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 392 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8 (Filed Under Seal) | 09/21/21 | 90 | 22,177–22,309 |
| 393 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8 (Filed Under Seal) | 09/22/21 | 90<br>91 | 22,310–22,393<br>22,394–22,442 |
| 394 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8 (Filed Under Seal) | 09/22/21 | 91 | 22,443–22,575 |
| 395 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8 (Filed Under Seal) | 09/22/21 | 91 | 22,576–22,609 |
| 396 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8 (Filed Under Seal) | 09/22/21 | 91<br>92<br>93 | 22,610–22,643<br>22,644–22,893<br>22,894–23,037 |
| 397 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8 (Filed Under Seal) | 09/22/21 | 93<br>94 | 23,038–23,143<br>23,144–23,174 |
| 398 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8 (Filed Under Seal) | 09/22/21 | 94 | 23,175–23,260 |
| 399 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8 (Filed Under Seal) | 09/22/21 | 94<br>95 | 23,261–23,393<br>23,394–23,535 |
| 400 | Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8 (Filed Under Seal) | 09/22/21 | 95<br>96 | 23,536–23,643<br>23,634–23,801 |
| 385 | Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6) (Filed Under Seal) | 09/21/21 | 86<br>87 | 21,369–21,393<br>21,394–21,484 |
| 386 | Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6) (Filed Under Seal) | 09/21/21 | 87 | 21,485–21,614 |
| 387 | Appendix to Defendants' Motion in Limine | 09/21/21 | 87 | 21,615–21,643 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | No. 13 (Volume 3 of 6) (Filed Under Seal) | | 88 | 21,644–21,744 |
| 388 | Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6) (Filed Under Seal) | 09/21/21 | 88 | 21,745–21,874 |
| 389 | Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6) (Filed Under Seal) | 09/21/21 | 88<br>89 | 21,875–21,893<br>21,894–22,004 |
| 390 | Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6) (Filed Under Seal) | 09/21/21 | 89 | 22,005–22,035 |
| 409 | Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6 (Filed Under Seal) | 09/22/21 | 102 | 25,205–25,226 |
| 410 | Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6 (Filed Under Seal) | 09/22/21 | 102 | 25,227–25,364 |
| 411 | Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6 (Filed Under Seal) | 09/22/21 | 102<br>103 | 25,365–25,393<br>25,394–25,494 |
| 412 | Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6 (Filed Under Seal) | 09/22/21 | 103 | 25,495–25,624 |
| 413 | Appendix to Defendants' Motion in Limine No. 14 – Volume 5 of 6 (Filed Under Seal) | 09/22/21 | 103<br>104 | 25,625–25,643<br>25,644–25,754 |
| 414 | Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6 (Filed Under Seal) | 09/22/21 | 104 | 25,755–25,785 |
| 373 | Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal) | 06/24/21 | 82<br>83<br>84 | 20,291–20,393<br>20,394–20,643<br>20,644–20,698 |
| 70 | Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/08/21 | 12<br>13<br>14 | 2875–3000<br>3001–3250<br>3251–3397 |
| 368 | Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time (Filed | 05/21/21 | 79<br>80<br>81 | 19,582–19,643<br>19,644–19,893<br>19,894–20,065 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Under Seal) | | | |
| 418 | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1 (Filed Under Seal) | 09/29/21 | 105<br>106 | 25,902–26,143<br>26,144–26,216 |
| 419 | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2 (Filed Under Seal) | 09/29/21 | 106<br>107 | 26,217–26,393<br>26,394–26,497 |
| 489 | Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43) (Filed Under Seal) | 09/29/21 | 144 | 35,703–35,713 |
| 75 | Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/19/21 | 14<br>15 | 3466–3500<br>3501–3658 |
| 316 | Case Appeal Statement | 04/06/22 | 67<br>68 | 16,695–16,750<br>16,751–16,825 |
| 356 | Case Appeal Statement | 10/12/22 | 74<br>75 | 18,468–18,500<br>18,501–18,598 |
| 16 | Civil Order to Statistically Close Case | 12/10/19 | 2 | 309 |
| 1 | Complaint (Business Court) | 04/15/19 | 1 | 1–17 |
| 284 | Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages | 02/10/22 | 53 | 13,005–13,028 |
| 435 | Defendant's Omnibus Offer of Proof for Second Phase of Trial (Filed Under Seal) | 12/14/21 | 111 | 27,496–27,505 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 311 | Defendants Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions on Order Shortening Time | 04/05/22 | 66 | 16,362–16,381 |
| 42 | Defendants' Answer to Plaintiffs' First Amended Complaint | 07/08/20 | 7 | 1541–1590 |
| 150 | Defendants' Answer to Plaintiffs' Second Amended Complaint | 10/08/21 | 22 | 5280–5287 |
| 198 | Defendants' Deposition Designations and Objections to Plaintiffs' Deposition Counter-Designations | 11/03/21 | 32 | 7778–7829 |
| 99 | Defendants' Errata to Their Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production | 05/03/21 | 17 | 4124–4127 |
| 288 | Defendants' Index of Trial Exhibit Redactions in Dispute | 02/16/22 | 53 | 13,063–13,073 |
| 462 | Defendants' Index of Trial Exhibit Redactions in Dispute (Filed Under Seal) | 02/10/22 | 128 | 31,662–31,672 |
| 235 | Defendants' Motion for Judgment as a Matter of Law | 11/17/21 | 41<br>42 | 10,250<br>10,251–10,307 |
| 375 | Defendants' Motion for Leave to File Defendants' Objection to the Special Master's Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Under Seal (Filed Under Seal) | 07/15/21 | 84 | 20,743–20,750 |
| 214 | Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at | 11/12/21 | 37 | 9153–9161 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Trial Under Seal | | | |
| 130 | Defendants' Motion for Partial Summary Judgment | 09/21/21 | 20 | 4770–4804 |
| 312 | Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 04/06/22 | 66 | 16,382–16,399 |
| 131 | Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations | 09/21/21 | 20 | 4805–4829 |
| 134 | Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9) | 09/21/21 | 20 | 4869–4885 |
| 401 | Defendants' Motion in Limine No. 11 Paired with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement (Filed Under Seal) | 09/22/21 | 96 | 23,802–23,823 |
| 403 | Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement (Filed Under Seal) | 09/22/21 | 96 | 23,860–23,879 |
| 135 | Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims | 09/21/21 | 20 | 4886–4918 |
| 136 | Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement | 09/21/21 | 20 | 4919–4940 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs | | | |
| 132 | Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations | 09/21/21 | 20 | 4830–4852 |
| 137 | Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 09/21/21 | 20 | 4941–4972 |
| 383 | Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6] (Filed Under Seal) | 09/21/21 | 86 | 21,314–21,343 |
| 384 | Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable (Filed Under Seal) | 09/21/21 | 86 | 21,344–21,368 |
| 138 | Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided | 09/22/21 | 20<br>21 | 4973–5000<br>5001–5030 |
| 139 | Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided | 09/22/21 | 21 | 5031–5054 |
| 140 | Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of | 09/22/21 | 21 | 5055–5080 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Plaintiffs Organizational, Management, and Ownership Structure, Including Flow of Funds Between Related Entities, Operating Companies, Parent Companies, and Subsidiaries | | | |
| 271 | Defendants' Motion to Apply the Statutory Cap on Punitive Damages | 12/30/21 | 50 | 12,342–12,363 |
| 71 | Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/11/21 | 14 | 3398–3419 |
| 52 | Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | 09/21/20 | 8<br>9 | 1998–2000<br>2001–2183 |
| 23 | Defendants' Motion to Dismiss | 03/12/20 | 3 | 553–698 |
| 32 | Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint | 05/26/20 | 5 | 1027–1172 |
| 348 | Defendants' Motion to Redact Portions of Trial Transcript | 10/06/22 | 72 | 17,979–17,989 |
| 304 | Defendants' Motion to Retax Costs | 03/21/22 | 62 | 15,374–15,388 |
| 277 | Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing on Defendants' Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time | 01/11/22 | 52 | 12,757–12,768 |
| 487 | Defendants' Motion to Supplement Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time (Filed Under Seal) | 05/24/21 | 143<br>144 | 35,635–35,643<br>35,644–35,648 |
| 169 | Defendants' Objection to Media Requests | 10/28/21 | 29 | 7004–7018 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 339 | Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees | 07/26/22 | 71 | 17,700–17,706 |
| 273 | Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law | 01/04/22 | 51 | 12,707–12,717 |
| 94 | Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order | 04/12/21 | 17 | 4059–4079 |
| 98 | Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time | 04/28/21 | 17 | 4109–4123 |
| 370 | Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality Designations (Filed April 15, 2021) (Filed Under Seal) | 06/01/21 | 82 | 20,152–20,211 |
| 61 | Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/26/20 | 11 | 2573–2670 |
| 151 | Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures | 10/08/21 | 22 | 5288–5294 |
| 64 | Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel | 11/02/20 | 11 | 2696–2744 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs' to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | | | |
| 60 | Defendants' Objections to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/23/20 | 10<br>11 | 2482–2500<br>2501–2572 |
| 199 | Defendants' Objections to Plaintiffs' Proposed Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders | 11/03/21 | 32 | 7830–7852 |
| 100 | Defendants' Objections to Plaintiffs' Proposed Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 05/05/21 | 17 | 4128–4154 |
| 108 | Defendants' Objections to Special Master Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Requests for Production of Documents | 06/17/21 | 17 | 4227–4239 |
| 431 | Defendants' Omnibus Offer of Proof (Filed Under Seal) | 11/22/21 | 109<br>110 | 27,100–27,143<br>27,144–27,287 |
| 14 | Defendants' Opposition to Fremont Emergency Services (MANDAVIA), Ltd.'s Motion to Remand | 06/21/19 | 1<br>2 | 139–250<br>251–275 |
| 18 | Defendants' Opposition to Plaintiffs' Amended Motion to Remand | 01/29/20 | 2 | 349–485 |
| 283 | Defendants' Opposition to Plaintiffs' Cross- | 02/10/22 | 52 | 12,997–13,000 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Motion for Entry of Judgment | | 53 | 13,001–13,004 |
| 322 | Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees | 04/20/22 | 69 | 17,036–17,101 |
| 155 | Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 10/18/21 | 22 | 5323–5333 |
| 141 | Defendants' Opposition to Plaintiffs' Motion in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges | 09/29/21 | 21 | 5081–5103 |
| 417 | Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal) | 09/29/21 | 104<br>105 | 25,869–25,893<br>25,894–25,901 |
| 50 | Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, Or, in The Alternative, Motion in Limine on Order Shortening Time | 09/04/20 | 8 | 1846–1932 |
| 56 | Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time | 10/06/20 | 10 | 2293–2336 |
| 251 | Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 11/22/21 | 47 | 11,609–11,631 |
| 89 | Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause | 03/22/21 | 16 | 3916–3966 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Why Defendants Should Not be Held in Contempt and for Sanctions | | | |
| 220 | Defendants' Proposed Jury Instructions (Contested) | 11/15/21 | 38 | 9427–9470 |
| 259 | Defendants' Proposed Second Phase Jury Instructions | 12/05/21 | 49 | 12,049–12,063 |
| 263 | Defendants' Proposed Second Phase Jury Instructions-Supplement | 12/07/21 | 49 | 12,136–12,142 |
| 313 | Defendants' Renewed Motion for Judgment as a Matter of Law | 04/06/22 | 66 | 16,400–16,448 |
| 421 | Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal) | 10/11/21 | 107<br>108 | 26,606–26,643<br>26,644–26,663 |
| 74 | Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/19/21 | 14 | 3449–3465 |
| 28 | Defendants' Reply in Support of Motion to Dismiss | 05/07/20 | 4 | 919–948 |
| 36 | Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint | 06/03/20 | 6 | 1310–1339 |
| 325 | Defendants' Reply in Support of Motion to Retax Costs | 05/04/22 | 69 | 17,122–17,150 |
| 457 | Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal) | 01/05/22 | 126 | 31,259–31,308 |
| 37 | Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint | 06/03/20 | 6 | 1340–1349 |
| 334 | Defendants' Response to Improper Supplement Entitled "Notice of | 06/28/22 | 71 | 17,579–17,593 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees" | | | |
| 286 | Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time | 02/15/22 | 53 | 13,047–13,053 |
| 225 | Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative Remedies | 11/16/21 | 40 | 9799–9806 |
| 12 | Defendants' Statement of Removal | 05/30/19 | 1 | 123–126 |
| 33 | Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief | 05/26/20 | 5 | 1173–1187 |
| 247 | Defendants' Supplemental Proposed Jury Instruction | 11/21/21 | 46 | 11,262–11,266 |
| 240 | Defendants' Supplemental Proposed Jury Instructions (Contested) | 11/19/21 | 44 | 10,947–10,952 |
| 48 | Errata | 08/04/20 | 7 | 1684 |
| 241 | Errata | 11/19/21 | 44 | 10,953 |
| 402 | Errata to Defendants' Motion in Limine No. 11 (Filed Under Seal) | 09/22/21 | 96 | 23,824–23,859 |
| 404 | Errata to Defendants' Motion in Limine No. 12 (Filed Under Seal) | 09/22/21 | 96<br>97 | 23,880–23,893<br>23,894–23,897 |
| 54 | Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories | 09/28/20 | 9 | 2196–2223 |
| 85 | Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for | 03/12/21 | 16 | 3884–3886 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Sanctions | | | |
| 238 | Errata to Source on Defense Contested Jury Instructions | 11/18/21 | 43 | 10,618–10,623 |
| 430 | Excerpts of Recorder's Transcript of Jury Trial – Day 13 (Filed Under Seal) | 11/16/21 | 109 | 27,093–27,099 |
| 427 | Excerpts of Recorder's Transcript of Jury Trial – Day 9 (Filed Under Seal) | 11/09/21 | 109 | 26,998–27003 |
| 481 | Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119) (Filed Under Seal) | 10/07/22 | 142 | 35,243–35,247 |
| 30 | First Amended Complaint | 05/15/20 | 4<br>5 | 973–1000<br>1001–1021 |
| 13 | Freemont Emergency Services (MANDAVIA), Ltd's Response to Statement of Removal | 05/31/19 | 1 | 127–138 |
| 226 | General Defense Verdict | 11/16/21 | 40 | 9807–9809 |
| 305 | Health Care Providers' Motion for Attorneys' Fees | 03/30/22 | 62 | 15,389–15,397 |
| 326 | Health Care Providers' Reply in Support of Motion for Attorneys' Fees | 05/04/22 | 69 | 17,151–17,164 |
| 294 | Health Care Providers' Verified Memorandum of Cost | 03/14/22 | 53 | 13,198–13,208 |
| 44 | Joint Case Conference Report | 07/17/20 | 7 | 1606–1627 |
| 164 | Joint Pretrial Memorandum Pursuant to EDRC 2.67 | 10/27/21 | 26<br>27 | 6486–6500<br>6501–6567 |
| 465 | Joint Status Report and Table Identifying | 03/04/22 | 128 | 31,888–31,893 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | the Redactions to Trial Exhibits That Remain in Dispute (Filed Under Seal) | | 129 | 31,894–31,922 |
| 221 | Jointly Submitted Jury Instructions | 11/15/21 | 38 | 9471–9495 |
| 255 | Jury Instructions | 11/29/21 | 48 | 11,957–11,999 |
| 264 | Jury Instructions Phase Two | 12/07/21 | 49 | 12,143–12,149 |
| 347 | Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket" | 10/06/22 | 72 | 17,973–17,978 |
| 156 | Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline) | 10/18/21 | 22 | 5334–5338 |
| 167 | Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC) | 10/28/21 | 28<br>28 | 6992–6997 |
| 168 | Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC) | 10/28/21 | 28<br>29 | 6998–7000<br>7001–7003 |
| 314 | Motion for New Trial | 04/06/22 | 66<br>67 | 16,449–16,500<br>16,501–16,677 |
| 119 | Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order | 08/10/21 | 18 | 4465–4486 |
| 79 | Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production | 02/18/21 | 15<br>16 | 3714–3750<br>3751–3756 |
| 488 | Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges (Filed Under Seal) | 09/21/21 | 144 | 35,649–35,702 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 382 | Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges (Filed Under Seal) | 09/21/21 | 86 | 21,260–21,313 |
| 133 | Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied | 09/21/21 | 20 | 4853–4868 |
| 11 | Motion to Remand | 05/24/19 | 1 | 101–122 |
| 432 | Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal) | 12/05/21 | 110 | 27,288–27,382 |
| 434 | Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal) | 12/13/21 | 111 | 27,401–27,495 |
| 267 | Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits | 12/15/21 | 50 | 12,294–12,302 |
| 275 | Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits | 01/10/22 | 51 | 12,739–12,747 |
| 276 | Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits | 01/10/22 | 51<br>52 | 12,748–12,750<br>12,751–12,756 |
| 268 | Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits | 12/15/21 | 50 | 12,303–12,311 |
| 315 | Notice of Appeal | 04/06/22 | 67 | 16,678–16,694 |
| 355 | Notice of Appeal | 10/12/22 | 73<br>74 | 18,126–18,250<br>18,251–18,467 |
| 292 | Notice of Entry of Judgment | 03/09/22 | 53 | 13,168–13,178 |
| 115 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 | 08/09/21 | 18 | 4403–4413 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection | | | |
| 116 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection | 08/09/21 | 18 | 4414–4424 |
| 127 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection | 09/16/21 | 19 | 4709–4726 |
| 128 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection | 09/16/21 | 19 | 4727–4747 |
| 129 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection | 09/16/21 | 19<br>20 | 4748–4750<br>4751–4769 |
| 200 | Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified | 11/03/21 | 32 | 7853–7874 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 340 | Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees | 08/02/22 | 71 | 17,707–17,725 |
| 351 | Notice of Entry of Order Approving Supplemental Attorney's Fee Award | 10/12/22 | 73 | 18,005–18,015 |
| 357 | Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript" | 10/13/22 | 75 | 18,599–18,608 |
| 40 | Notice of Entry of Order Denying Defendants' (1) Motion to Dismiss First Amended Complaint; and (2) Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief | 06/24/20 | 6<br>7 | 1472–1500<br>1501–1516 |
| 274 | Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law | 01/06/22 | 51 | 12,718–12,738 |
| 352 | Notice of Entry of Order Denying Defendants' Motion for New Trial | 10/12/22 | 73 | 18,016–18,086 |
| 154 | Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order | 10/14/21 | 22 | 5309–5322 |
| 161 | Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment | 10/25/21 | 25 | 6116–6126 |
| 338 | Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 07/19/22 | 71 | 17,689–17,699 |
| 171 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations | 11/01/21 | 29 | 7040–7051 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 172 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations | 11/01/21 | 29 | 7052–7063 |
| 173 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges | 11/01/21 | 29 | 7064–7075 |
| 174 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied | 11/01/21 | 29 | 7076–7087 |
| 175 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement | 11/01/21 | 29 | 7088–7099 |
| 176 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6] | 11/01/21 | 29 | 7100–7111 |
| 177 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided | 11/01/21 | 29 | 7112–7123 |
| 178 | Notice of Entry of Order Denying | 11/01/21 | 29 | 7124–7135 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided | | | |
| 179 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9) | 11/01/21 | 29 | 7136–7147 |
| 180 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement | 11/01/21 | 29 | 7148–7159 |
| 181 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims | 11/01/21 | 29 | 7160–7171 |
| 182 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs | 11/01/21 | 29 | 7172–7183 |
| 183 | Notice of Entry of Order Denying | 11/01/21 | 29 | 7184–7195 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony Regarding the TeamHealth Plaintiffs Policy not to Balance Bill | | | |
| 184 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D. | 11/01/21 | 29 | 7196–7207 |
| 185 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts | 11/01/21 | 29 | 7208–7219 |
| 186 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 11/01/21 | 29 | 7220–7231 |
| 187 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments | 11/01/21 | 29 | 7232–7243 |
| 188 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight | 11/01/21 | 29<br>30 | 7244–7250<br>7251–7255 |
| 189 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020 | 11/01/21 | 30 | 7256–7267 |
| 191 | Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to | 11/01/21 | 30 | 7280–7291 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services | | | |
| 190 | Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained Expert Robert Frantz, M.D. | 11/01/21 | 30 | 7268–7279 |
| 293 | Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages | 03/09/22 | 53 | 13,179–13,197 |
| 62 | Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time | 10/27/20 | 11 | 2671–2683 |
| 78 | Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 02/04/21 | 15 | 3703–3713 |
| 193 | Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers | 11/01/21 | 30 | 7355–7366 |
| 353 | Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law | 10/12/22 | 73 | 18,087–18,114 |
| 97 | Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production | 04/26/21 | 17 | 4096–4108 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 77 | Notice of Entry of Order Granting Defendants' Motion for Appointment of Special Master | 02/02/21 | 15 | 3693–3702 |
| 269 | Notice of Entry of Order Granting Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal | 12/27/21 | 50 | 12,312–12,322 |
| 202 | Notice of Entry of Order Granting Defendants' Motion in Limine No. 17 | 11/04/21 | 33 | 8092–8103 |
| 203 | Notice of Entry of Order Granting Defendants' Motion in Limine No. 25 | 11/04/21 | 33 | 8104–8115 |
| 204 | Notice of Entry of Order Granting Defendants' Motion in Limine No. 37 | 11/04/21 | 33 | 8116–8127 |
| 205 | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 9 | 11/04/21 | 33 | 8128–8140 |
| 206 | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 21 | 11/04/21 | 33 | 8141–8153 |
| 207 | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 22 | 11/04/21 | 33 | 8154–8165 |
| 341 | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Retax Costs | 08/02/22 | 71 | 17,726–17,739 |
| 358 | Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits | 10/18/22 | 75<br>76 | 18,609–18,750<br>18,751–18,755 |
| 215 | Notice of Entry of Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the | 11/12/21 | 37 | 9162–9173 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Court's Discovery Orders | | | |
| 147 | Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time | 10/07/21 | 21 | 5235–5245 |
| 242 | Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment | 11/19/21 | 44 | 10,954–10,963 |
| 192 | Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims | 11/01/21 | 30 | 7292–7354 |
| 63 | Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 10/27/20 | 11 | 2684–2695 |
| 335 | Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 06/29/22 | 71 | 17,594–17,609 |
| 281 | Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions | 01/31/22 | 52 | 12,969–12,979 |
| 114 | Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 08/03/21 | 18 | 4383–4402 |
| 53 | Notice of Entry of Order Granting, in Part Plaintiffs' Motion to Compel Defendants' | 09/28/20 | 9 | 2184–2195 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Production of Claims for At-Issue Claims, Or, in The Alternative, Motion in Limine | | | |
| 102 | Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question | 05/26/21 | 17 | 4157–4165 |
| 22 | Notice of Entry of Order Re: Remand | 02/27/20 | 3 | 543–552 |
| 142 | Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time | 09/29/21 | 21 | 5104–5114 |
| 66 | Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time | 11/09/20 | 12 | 2775–2785 |
| 285 | Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits | 02/14/22 | 53 | 13,029–13,046 |
| 354 | Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to Docket | 10/12/22 | 73 | 18,115–18,125 |
| 86 | Notice of Entry of Report and Recommendation #1 | 03/16/21 | 16 | 3887–3894 |
| 120 | Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' | 08/11/21 | 18 | 4487–4497 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Witnesses Testified | | | |
| 91 | Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order | 03/29/21 | 16 | 3971–3980 |
| 95 | Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time | 04/15/21 | 17 | 4080–4091 |
| 104 | Notice of Entry of Report and Recommendation #7 Regarding Defendants' Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents | 06/03/21 | 17 | 4173–4184 |
| 41 | Notice of Entry of Stipulated Confidentiality and Protective Order | 06/24/20 | 7 | 1517–1540 |
| 69 | Notice of Entry of Stipulated Electronically Stored Information Protocol Order | 01/08/21 | 12 | 2860–2874 |
| 289 | Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits | 02/17/22 | 53 | 13,074–13,097 |
| 360 | Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts | 10/25/22 | 76 | 18,759–18,769 |
| 282 | Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions | 02/08/22 | 52 | 12,980–12,996 |
| 111 | Notice of Entry Report and Recommendations #9 Regarding Pending Motions | 07/01/21 | 18 | 4313–4325 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 490 | Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021 (Filed Under Seal) | 04/18/23 | 144 | 35,714–35,812 |
| 361 | Notice of Filing of Writ Petition | 11/17/22 | 76 | 18,770–18855 |
| 24 | Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief | 03/13/20 | 3<br>4 | 699–750<br>751 |
| 324 | Notice of Posting *Supersedeas* Bond | 04/29/22 | 69 | 17,114–17,121 |
| 10 | Notice of Removal to Federal Court | 05/14/19 | 1 | 42–100 |
| 333 | Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees | 06/24/22 | 70<br>71 | 17,470–17,500<br>17,501–17,578 |
| 291 | Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages | 03/04/22 | 53 | 13,161–13,167 |
| 345 | Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial | 09/13/22 | 72 | 17,941–17,950 |
| 377 | Objection to R&R #11 Regarding United's (Filed Under Seal)Motion to Compel Documents About Which Plaintiffs' Witnesses Testified (Filed Under Seal) | 08/25/21 | 84<br>85 | 20,864–20,893<br>20,894–20,898 |
| 320 | Opposition to Defendants' Motion to Retax Costs | 04/13/22 | 68 | 16,856–16,864 |
| 153 | Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time | 10/12/21 | 22 | 5301–5308 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 20 | Order | 02/20/20 | 3 | 519–524 |
| 21 | Order | 02/24/20 | 3 | 525–542 |
| 337 | Order Amending Oral Ruling Granting Defendants' Motion to Retax | 07/01/22 | 71 | 17,682–17,688 |
| 2 | Peremptory Challenge of Judge | 04/17/19 | 1 | 18–19 |
| 415 | Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13 (Filed Under Seal) | 09/29/21 | 104 | 25,786–25,850 |
| 416 | Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14 (Filed Under Seal) | 09/29/21 | 104 | 25,851–25,868 |
| 145 | Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time | 10/04/21 | 21 | 5170–5201 |
| 422 | Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal) | 10/17/21 | 108 | 26,664–26,673 |
| 378 | Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal) | 09/21/21 | 85 | 20,899–20,916 |
| 380 | Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal) | 09/21/21 | 85 | 21,077–21,089 |
| 149 | Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument | 10/08/21 | 22 | 5265–5279 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Regarding the Fact that Plaintiffs Have Dismissed Certain Claims and Parties on Order Shortening Time | | | |
| 363 | Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal) | 09/28/20 | 78 | 19,144–19,156 |
| 49 | Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, or, in the Alternative, Motion in Limine on Order Shortening Time | 08/28/20 | 7<br>8 | 1685–1700<br>1701–1845 |
| 250 | Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time | 11/22/21 | 47 | 11,594–11,608 |
| 194 | Plaintiffs' Notice of Amended Exhibit List | 11/01/21 | 30 | 7367–7392 |
| 208 | Plaintiffs' Notice of Deposition Designations | 11/04/21 | 33<br>34 | 8166–8250<br>8251–8342 |
| 152 | Plaintiffs' Objections to Defendants' Pretrial Disclosures | 10/08/21 | 22 | 5295–5300 |
| 328 | Plaintiffs' Opposition to Defendants' Motion for New Trial | 05/04/22 | 69<br>70 | 17,179–17,250<br>17,251–17,335 |
| 420 | Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment (Filed Under Seal) | 10/05/21 | 107 | 26,498–26,605 |
| 327 | Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 05/04/22 | 69 | 17,165–17,178 |
| 144 | Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals | 09/29/21 | 21 | 5155–5169 |
| 143 | Plaintiffs' Opposition to Defendants' Motion | 09/29/21 | 21 | 5115–5154 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges | | | |
| 279 | Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment | 01/20/22 | 52 | 12,773–12,790 |
| 374 | Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal) | 07/06/21 | 84 | 20,699–20,742 |
| 25 | Plaintiffs' Opposition to Defendants' Motion to Dismiss | 03/26/20 | 4 | 752–783 |
| 34 | Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint | 05/29/20 | 5<br>6 | 1188–1250<br>1251–1293 |
| 349 | Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript | 10/07/22 | 72 | 17,990–17,993 |
| 278 | Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing | 01/12/22 | 52 | 12,769–12,772 |
| 369 | Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time (Filed Under Seal) | 06/01/21 | 81<br>82 | 20,066–20,143<br>20,144–20,151 |
| 329 | Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter of Law | 05/05/22 | 70 | 17,336–17,373 |
| 317 | Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay | 04/07/22 | 68 | 16,826–16,831 |
| 35 | Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended | 05/29/20 | 6 | 1294–1309 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Complaint Addressing Plaintiffs' Eighth Claim for Relief | | | |
| 83 | Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production | 03/04/21 | 16 | 3833–3862 |
| 55 | Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time | 09/29/20 | 9-10 | 2224–2292 |
| 72 | Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time | 01/12/21 | 14 | 3420–3438 |
| 122 | Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order | 08/24/21 | 19 | 4528–4609 |
| 270 | Plaintiffs' Opposition to United's Motion to Seal | 12/29/21 | 50 | 12,323–12,341 |
| 222 | Plaintiffs' Proposed Jury Instructions (Contested) | 11/15/21 | 38<br>39 | 9496–9500<br>9501–9513 |
| 260 | Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form | 12/06/21 | 49 | 12,064–12,072 |
| 243 | Plaintiffs' Proposed Special Verdict Form | 11/19/21 | 44 | 10,964–10,973 |
| 227 | Plaintiffs' Proposed Verdict Form | 11/16/21 | 40 | 9810–9819 |
| 84 | Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions | 03/08/21 | 16 | 3863–3883 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 287 | Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment | 02/15/22 | 53 | 13,054–13,062 |
| 364 | Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal) | 04/01/21 | 78 | 19,157–19,176 |
| 366 | Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order (Filed Under Seal) | 04/19/21 | 78<br>79 | 19,389–19,393<br>19,394–19,532 |
| 195 | Plaintiffs' Response to Defendants' Objection to Media Requests | 11/01/21 | 30 | 7393–7403 |
| 371 | Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions (Filed Under Seal) | 06/16/21 | 82 | 20,212–20,265 |
| 376 | Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions (Filed Under Seal) | 07/22/21 | 84 | 20,751–20,863 |
| 110 | Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended | 06/24/21 | 18 | 4281–4312 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Third Set of Request for Production of Documents | | | |
| 367 | Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time (Filed Under Seal) | 05/05/21 | 79 | 19,533–19,581 |
| 426 | Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal) | 11/08/21 | 109 | 26,965–26,997 |
| 246 | Plaintiffs' Second Supplemental Jury Instructions (Contested) | 11/20/21 | 46 | 11,255–11,261 |
| 261 | Plaintiffs' Supplement to Proposed Second Phase Jury Instructions | 12/06/21 | 49 | 12,072–12,077 |
| 236 | Plaintiffs' Supplemental Jury Instruction (Contested) | 11/17/21 | 42 | 10,308–10,313 |
| 248 | Plaintiffs' Third Supplemental Jury Instructions (Contested) | 11/21/21 | 46 | 11,267–11,272 |
| 216 | Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies | 11/12/21 | 37 | 9174–9184 |
| 223 | Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim | 11/15/21 | 39 | 9514–9521 |
| 218 | Plaintiffs' Trial Brief Regarding Specific Price Term | 11/14/21 | 38 | 9417–9425 |
| 428 | Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial (Filed Under Seal) | 11/11/21 | 109 | 27,004–27,055 |
| 211 | Recorder's Amended Transcript of Jury Trial – Day 9 | 11/09/21 | 35 | 8515–8723 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 73 | Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only) | 01/13/21 | 14 | 3439–3448 |
| 125 | Recorder's Partial Transcript of Proceedings Re: Motions Hearing | 09/09/21 | 19 | 4667–4680 |
| 126 | Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans) | 09/15/21 | 19 | 4681–4708 |
| 31 | Recorder's Transcript of Hearing All Pending Motions | 05/15/20 | 5 | 1022–1026 |
| 88 | Recorder's Transcript of Hearing All Pending Motions | 03/18/21 | 16 | 3910–3915 |
| 90 | Recorder's Transcript of Hearing All Pending Motions | 03/25/21 | 16 | 3967–3970 |
| 96 | Recorder's Transcript of Hearing All Pending Motions | 04/21/21 | 17 | 4092–4095 |
| 82 | Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request) | 03/03/21 | 16 | 3824–3832 |
| 101 | Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form | 05/12/21 | 17 | 4155–4156 |
| 107 | Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form | 06/09/21 | 17 | 4224–4226 |
| 92 | Recorder's Transcript of Hearing Motion to Associate Counsel on OST | 04/01/21 | 16 | 3981–3986 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 483 | Recorder's Transcript of Hearing re Hearing (Filed Under Seal) | 10/13/22 | 142 | 35,259–35,263 |
| 346 | Recorder's Transcript of Hearing Re: Hearing | 09/22/22 | 72 | 17,951–17,972 |
| 359 | Recorder's Transcript of Hearing Status Check | 10/20/22 | 76 | 18,756–18,758 |
| 162 | Recorder's Transcript of Jury Trial – Day 1 | 10/25/21 | 25<br>26 | 6127–6250<br>6251–6279 |
| 213 | Recorder's Transcript of Jury Trial – Day 10 | 11/10/21 | 36<br>37 | 8933–9000<br>9001–9152 |
| 217 | Recorder's Transcript of Jury Trial – Day 11 | 11/12/21 | 37<br>38 | 9185–9250<br>9251–9416 |
| 224 | Recorder's Transcript of Jury Trial – Day 12 | 11/15/21 | 39<br>40 | 9522–9750<br>9751–9798 |
| 228 | Recorder's Transcript of Jury Trial – Day 13 | 11/16/21 | 40<br>41 | 9820–10,000<br>10,001–10,115 |
| 237 | Recorder's Transcript of Jury Trial – Day 14 | 11/17/21 | 42<br>43 | 10,314–10,500<br>10,501–10,617 |
| 239 | Recorder's Transcript of Jury Trial – Day 15 | 11/18/21 | 43<br>44 | 10,624–10,750<br>10,751–10,946 |
| 244 | Recorder's Transcript of Jury Trial – Day 16 | 11/19/21 | 44<br>45 | 10,974–11,000<br>11,001–11,241 |
| 249 | Recorder's Transcript of Jury Trial – Day 17 | 11/22/21 | 46<br>47 | 11,273–11,500<br>11.501–11,593 |
| 253 | Recorder's Transcript of Jury Trial – Day 18 | 11/23/21 | 47<br>48 | 11,633–11,750<br>11,751–11,907 |
| 254 | Recorder's Transcript of Jury Trial – Day 19 | 11/24/21 | 48 | 11,908–11,956 |
| 163 | Recorder's Transcript of Jury Trial – Day 2 | 10/26/21 | 26 | 6280–6485 |
| 256 | Recorder's Transcript of Jury Trial – Day 20 | 11/29/21 | 48<br>49 | 12,000<br>12,001–12,034 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 262 | Recorder's Transcript of Jury Trial – Day 21 | 12/06/21 | 49 | 12,078–,12,135 |
| 266 | Recorder's Transcript of Jury Trial – Day 22 | 12/07/21 | 49<br>50 | 12,153–12,250<br>12,251–12,293 |
| 165 | Recorder's Transcript of Jury Trial – Day 3 | 10/27/21 | 27<br>28 | 6568–6750<br>6751–6774 |
| 166 | Recorder's Transcript of Jury Trial – Day 4 | 10/28/21 | 28 | 6775–6991 |
| 196 | Recorder's Transcript of Jury Trial – Day 5 | 11/01/21 | 30<br>31 | 7404–7500<br>7501–7605 |
| 197 | Recorder's Transcript of Jury Trial – Day 6 | 11/02/21 | 31<br>32 | 7606–7750<br>7751–7777 |
| 201 | Recorder's Transcript of Jury Trial – Day 7 | 11/03/21 | 32<br>33 | 7875–8000<br>8001–8091 |
| 210 | Recorder's Transcript of Jury Trial – Day 8 | 11/08/21 | 34<br>35 | 8344–8500<br>8501–8514 |
| 212 | Recorder's Transcript of Jury Trial – Day 9 | 11/09/21 | 35<br>36 | 8724–8750<br>8751–8932 |
| 27 | Recorder's Transcript of Proceedings Re: Motions | 04/03/20 | 4 | 909–918 |
| 76 | Recorder's Transcript of Proceedings Re: Motions | 01/21/21 | 15 | 3659–3692 |
| 80 | Recorder's Transcript of Proceedings Re: Motions | 02/22/21 | 16 | 3757–3769 |
| 81 | Recorder's Transcript of Proceedings Re: Motions | 02/25/21 | 16 | 3770–3823 |
| 93 | Recorder's Transcript of Proceedings Re: Motions | 04/09/21 | 16<br>17 | 3987–4000<br>4001–4058 |
| 103 | Recorder's Transcript of Proceedings Re: Motions | 05/28/21 | 17 | 4166–4172 |
| 43 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 07/09/20 | 7 | 1591–1605 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 45 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 07/23/20 | 7 | 1628–1643 |
| 58 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 10/08/20 | 10 | 2363–2446 |
| 59 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 10/22/20 | 10 | 2447–2481 |
| 65 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 11/04/20 | 11<br>12 | 2745–2750<br>2751–2774 |
| 67 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 12/23/20 | 12 | 2786–2838 |
| 68 | Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans) | 12/30/20 | 12 | 2839–2859 |
| 105 | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/03/21 | 17 | 4185–4209 |
| 106 | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/04/21 | 17 | 4210–4223 |
| 109 | Recorder's Transcript of Proceedings Re: Motions Hearing | 06/23/21 | 17<br>18 | 4240–4250<br>4251–4280 |
| 113 | Recorder's Transcript of Proceedings Re: Motions Hearing | 07/29/21 | 18 | 4341–4382 |
| 123 | Recorder's Transcript of Proceedings Re: Motions Hearing | 09/02/21 | 19 | 4610–4633 |
| 121 | Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only) | 08/17/21 | 18<br>19 | 4498–4500<br>4501–4527 |
| 29 | Recorder's Transcript of Proceedings Re: Pending Motions | 05/14/20 | 4 | 949-972 |
| 51 | Recorder's Transcript of Proceedings Re: Pending Motions | 09/09/20 | 8 | 1933–1997 |
| 15 | Rely in Support of Motion to Remand | 06/28/19 | 2 | 276–308 |
| 124 | Reply Brief on "Motion for Order to Show | 09/08/21 | 19 | 4634–4666 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order" | | | |
| 19 | Reply in Support of Amended Motion to Remand | 02/05/20 | 2<br>3 | 486–500<br>501–518 |
| 330 | Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment | 06/22/22 | 70 | 17,374–17,385 |
| 57 | Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures | 10/07/20 | 10 | 2337–2362 |
| 331 | Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law | 06/22/22 | 70 | 17,386–17,411 |
| 332 | Reply in Support of Motion for New Trial | 06/22/22 | 70 | 17,412–17,469 |
| 87 | Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production | 03/16/21 | 16 | 3895–3909 |
| 344 | Reply in Support of Supplemental Attorney's Fees Request | 08/22/22 | 72 | 17,935–17,940 |
| 229 | Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties | 11/16/21 | 41 | 10,116–10,152 |
| 318 | Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*) | 04/07/22 | 68 | 16,832–16,836 |
| 245 | Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim | 11/19/21 | 45<br>46 | 11,242–11,250<br>11,251–11,254 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 230 | Response to Plaintiffs' Trial Brief Regarding Specific Price Term | 11/16/21 | 41 | 10,153–10,169 |
| 424 | Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal) | 10/21/21 | 109 | 26,931–26,952 |
| 148 | Second Amended Complaint | 10/07/21 | 21<br>22 | 5246–5250<br>5251–5264 |
| 458 | Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal) | 01/05/22 | 126<br>127 | 31,309–31,393<br>31,394–31,500 |
| 231 | Special Verdict Form | 11/16/21 | 41 | 10,169–10,197 |
| 257 | Special Verdict Form | 11/29/21 | 49 | 12,035–12,046 |
| 265 | Special Verdict Form | 12/07/21 | 49 | 12,150–12,152 |
| 6 | Summons – Health Plan of Nevada, Inc. | 04/30/19 | 1 | 29–31 |
| 9 | Summons – Oxford Health Plans, Inc. | 05/06/19 | 1 | 38–41 |
| 8 | Summons – Sierra Health and Life Insurance Company, Inc. | 04/30/19 | 1 | 35–37 |
| 7 | Summons – Sierra Health-Care Options, Inc. | 04/30/19 | 1 | 32–34 |
| 3 | Summons - UMR, Inc. dba United Medical Resources | 04/25/19 | 1 | 20–22 |
| 4 | Summons – United Health Care Services Inc. dba UnitedHealthcare | 04/25/19 | 1 | 23–25 |
| 5 | Summons – United Healthcare Insurance Company | 04/25/19 | 1 | 26–28 |
| 433 | Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits (Filed | 12/08/21 | 110<br>111 | 27,383–27,393<br>27,394–27,400 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Under Seal) | | | |
| 170 | Supplement to Defendants' Objection to Media Requests | 10/31/21 | 29 | 7019–7039 |
| 439 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18 (Filed Under Seal) | 12/24/21 | 114 | 28,189–28,290 |
| 440 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18 (Filed Under Seal) | 12/24/21 | 114<br>115 | 28,291–28,393<br>28,394–28,484 |
| 441 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal) | 12/24/21 | 115<br>116 | 28,485–28,643<br>28,644–28,742 |
| 442 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 (Filed Under Seal) | 12/24/21 | 116<br>117 | 28,743–28,893<br>28,894–28,938 |
| 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 |
| 444 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 (Filed Under Seal) | 12/24/21 | 117<br>118 | 29,085–29,143<br>29,144–29,219 |
| 445 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18 (Filed Under Seal) | 12/24/21 | 118 | 29,220–29,384 |
| 446 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18 (Filed Under Seal) | 12/24/21 | 118<br>119 | 29,385–29,393<br>29,394–29,527 |
| 447 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 (Filed Under Seal) | 12/24/21 | 119<br>120 | 29,528–29,643<br>29,644–29,727 |
| 448 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial | 12/24/21 | 120<br>121 | 29,728–29,893<br>29,894–29,907 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | Exhibits – Volume 10 of 18 (Filed Under Seal) | | | |
| 449 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18 (Filed Under Seal) | 12/24/21 | 121 | 29,908–30,051 |
| 450 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 (Filed Under Seal) | 12/24/21 | 121<br>122 | 30,052–30,143<br>30,144–30,297 |
| 451 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal) | 12/24/21 | 122<br>123 | 30,298–30,393<br>30,394–30,516 |
| 452 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal) | 12/24/21 | 123<br>124 | 30,517–30,643<br>30,644–30,677 |
| 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 |
| 454 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 (Filed Under Seal) | 12/24/21 | 124<br>125 | 30,836–30,893<br>30,894–30,952 |
| 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 |
| 456 | Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 (Filed Under | 12/24/21 | 125<br>126 | 30,123–31,143<br>31,144–31,258 |

| Tab | Document | Date | Vol. | Pages |
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| | Seal) | | | |
| 466 | Transcript of Proceedings re Hearing Regarding Unsealing Record (Filed Under Seal) | 10/05/22 | 129 | 31,923–31,943 |
| 350 | Transcript of Proceedings re Status Check | 10/10/22 | 72<br>73 | 17,994–18,000<br>18,001–18,004 |
| 467 | Transcript of Proceedings re Status Check (Filed Under Seal) | 10/06/22 | 129 | 31,944–31,953 |
| 157 | Transcript of Proceedings Re: Motions | 10/19/21 | 22<br>23 | 5339–5500<br>5501–5561 |
| 160 | Transcript of Proceedings Re: Motions | 10/22/21 | 24<br>25 | 5908–6000<br>6001–6115 |
| 459 | Transcript of Proceedings Re: Motions (Filed Under Seal) | 01/12/22 | 127 | 31,501–31,596 |
| 460 | Transcript of Proceedings Re: Motions (Filed Under Seal) | 01/20/22 | 127<br>128 | 31,597–31,643<br>31,644–31,650 |
| 461 | Transcript of Proceedings Re: Motions (Filed Under Seal) | 01/27/22 | 128 | 31,651–31,661 |
| 146 | Transcript of Proceedings Re: Motions (Via Blue Jeans) | 10/06/21 | 21 | 5202–5234 |
| 290 | Transcript of Proceedings Re: Motions Hearing | 02/17/22 | 53 | 13,098–13,160 |
| 319 | Transcript of Proceedings Re: Motions Hearing | 04/07/22 | 68 | 16,837–16,855 |
| 323 | Transcript of Proceedings Re: Motions Hearing | 04/21/22 | 69 | 17,102–17,113 |
| 336 | Transcript of Proceedings Re: Motions Hearing | 06/29/22 | 71 | 17,610–17,681 |
| 463 | Transcript of Proceedings Re: Motions Hearing (Filed Under Seal) | 02/10/22 | 128 | 31,673–31,793 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| 464 | Transcript of Proceedings Re: Motions Hearing (Filed Under Seal) | 02/16/22 | 128 | 31,794–31,887 |
| 38 | Transcript of Proceedings, All Pending Motions | 06/05/20 | 6 | 1350–1384 |
| 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 |
| 425 | Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal) | 10/31/21 | 109 | 26,953–26,964 |
| 232 | Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract | 11/16/21 | 41 | 10,198–10,231 |
| 233 | Trial Brief Regarding Jury Instructions on Unjust Enrichment | 11/16/21 | 41 | 10,232–10,248 |
| 484 | Trial Exhibit D5499 (Filed Under Seal) | | 142<br>143 | 35,264–35,393<br>35,394–35,445 |
| 362 | Trial Exhibit D5502 | | 76<br>77 | 18,856–19,000<br>19,001–19,143 |
| 485 | Trial Exhibit D5506 (Filed Under Seal) | | 143 | 35,446 |
| 372 | United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal) | 06/24/21 | 82 | 20,266–20,290 |
| 112 | United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified | 07/12/21 | 18 | 4326–4340 |

| Tab | Document | Date | Vol. | Pages |
|---|---|---|---|---|
| | on Order Shortening Time | | | |
| 258 | Verdict(s) Submitted to Jury but Returned Unsigned | 11/29/21 | 49 | 12,047–12,048 |

## 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.

Electronic notification will be sent to the following:

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I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
200 Lewis Avenue
Las Vegas, Nevada 89155

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*/s/ Jessie M. Helm*
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**Cc:** Phillips, Ellie <ephillips@omm.com>; Fowler, Jeffrey <jfowler@omm.com>; Kapolnai, Emily <EKapolnai@lewisroca.com>; Kelley, Cynthia <CKelley@lewisroca.com>
**Subject:** RE: UHC/Fremont sealing order

Mr. McManis,

We are filing the appendix now and will fill in the docket numbers in footnote 1 of the order as soon as all the volumes have been filed. Could you please forward the approval of Ms. Lundvall (or that of another local attorney) approving use of her e-signature on the order? We'll need to attach that to the submission.

Thank you,
Jessie

**Jessica Helm**
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**Subject:** Re: UHC/Fremont sealing order

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**Subject:** RE: UHC/Fremont sealing order



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**CSERV**

DISTRICT COURT
CLARK COUNTY, NEVADA

| | |
|---|---|
| Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s)<br><br>vs.<br><br>United Healthcare Insurance Company, Defendant(s) | CASE NO: A-19-792978-B<br><br>DEPT. NO. Department 27 |

**AUTOMATED CERTIFICATE OF SERVICE**

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 10/10/2022

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**RTRAN**

DISTRICT COURT

CLARK COUNTY, NEVADA

| | |
|---|---|
| FREMONT EMERGENCY SERVICES (MANDAVIA) LTD., Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, Defendant. | CASE#: A-19-792978-B<br>DEPT. XXVII |

BEFORE THE HONORABLE NANCY L. ALLF, DISTRICT COURT JUDGE

THURSDAY, OCTOBER 20, 2022

***RECORDER'S TRANSCRIPT OF HEARING***
**STATUS CHECK**

Appearances:

For the Plaintiff: No appearances

For the Defendant: ABRAHAM G. SMITH, ESQ. (via Videoconference)

RECORDED BY: BRYNN WHITE, COURT RECORDER



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Las Vegas, Nevada, Thursday, October 20, 2022

[Case called at 10:44 a.m.]

THE COURT: Let me start with Fremont versus United. Did anyone check in?

MR. SMITH: Good morning, Your Honor.

THE COURT: Yeah. Okay. Fremont. Your appearance, please.

MR. SMITH: This is Abe Smith for Defendants.

THE COURT: Thank you. All right. So, when I looked at this, Mr. Smith, the only thing I needed was the end of the 30 day stay, notice of entry went out on October 13th, and I had asked the parties to stipulate to that, to protect my Court Recorder, so that she wouldn't violate the stay, unintentionally --

MR. SMITH: Right.

THE COURT: -- of course.

MR. SMITH: So we've submitted a stipulation to your chambers. And, I suppose I should clarify, it says that the stay expires November 14th. That means that the stay would last through November 14th, and then on November 15th if nothing has happened then it would be unsealed.

THE COURT: All right. And I -- again, I haven't looked at the order inbox since the late afternoon yesterday. I'll take you at your word and get that turned around for you.

MR. SMITH: Very good, Your Honor.



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THE COURT: Thank you for your appearance.

MR. SMITH: Thank you.

[Hearing concluded at 10:45 a.m.]

* * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Brynn White

Brynn White
Court Recorder/Transcriber



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**DISTRICT COURT**

**CLARK COUNTY, NEVADA**

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: XXVII

**NOTICE OF ENTRY OF STIPULATION AND ORDER REGARDING EXPIRATION OF TEMPORARY STAY FOR SEALED REDACTED TRANSCRIPTS**

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Please take notice that a Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts was entered on October 20, 2022, a copy of which is attached hereto.

Dated this 25th day of October, 2022.

McDONALD CARANO LLP

By: */s/ Pat Lundvall*

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018760

## CERTIFICATE OF SERVICE

I certify that I am an employee of McDonald Carano LLP, and that on this 25th day of October, 2022, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF STIPULATION AND ORDER REGARDING EXPIRATION OF TEMPORARY STAY FOR SEALED REDACTED TRANSCRIPTS** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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*Attorneys for Plaintiffs*

**DISTRICT COURT**

**CLARK COUNTY, NEVADA**

| | |
|---|---|
| FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,<br><br>Plaintiffs,<br><br>vs.<br><br>UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,<br><br>Defendants. | Case No.: A-19-792978-B<br>Dept. No.: XXVII<br><br>**STIPULATION AND ORDER REGARDING EXPIRATION OF TEMPORARY STAY FOR SEALED REDACTED TRANSCRIPTS** |



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Plaintiffs Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively, "Plaintiffs"); and Defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Co., Inc.; and Health Plan of Nevada, Inc. (collectively, "Defendants") stipulate and agree as follows:

1. On October 5, 2022, the Court held a Status Conference regarding sealing issues. The Court directed plaintiffs to prepare an order to unseal all trial transcripts for entry that day.

2. On October 6, 2022, Defendants filed a Motion to Redact Portions of Trial Transcript (the "Motion"). The Court then held an emergency telephonic status conference regarding same. Plaintiffs filed their opposition on October 7, 2022.

3. On October 10, 2022, a third Status Conference was held that the Motion was denied, and it was further determined that Defendants would be entitled to a 30-day automatic stay under NRCP 62(a).

4. The Court signed its Order denying the Motion but granting the NRCP 62(a) stay on October 12, 2022. Notice of entry of that Order was filed and served on October 13, 2022.

5. On October 10, 2022, the Court also signed its "Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits," which likewise included a stay under NRCP 62(a). Notice of entry of that Order was filed and served on October 18, 2022.

6. Accordingly, Plaintiffs and Defendants hereby stipulate and agree that temporary stay set forth in these orders expires on November 14, 2022.

7. This stipulation shall have no effect on any other of the Court's orders, final judgment, and any respective stays pending appeal pursuant to NRCP 62(d) and the supersedeas bond.

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**ORDER**

SO ORDERED.

Dated this 20th day of October, 2022

Nancy L Allf

00A 217 7192 8D4D
Nancy Allf
District Court Judge

Dated this 19th day of October, 2022.
Respectfully submitted by:

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**CSERV**

DISTRICT COURT
CLARK COUNTY, NEVADA

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| Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s)<br><br>vs.<br><br>United Healthcare Insurance Company, Defendant(s) | CASE NO: A-19-792978-B<br><br>DEPT. NO. Department 27 |

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**DISTRICT COURT**

**CLARK COUNTY, NEVADA**

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

Case No.: A-19-792978-B
Dept. No.: 27

**NOTICE OF FILING OF WRIT PETITION**









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UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

**NOTICE OF FILING OF WRIT PETITION**

Please take notice that defendants United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS"), which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc., filed in this matter a petition for writ of mandamus or, alternatively, prohibition with the Supreme Court on November 17, 2022. (Nev. Sup. Ct. Case No. 85656.) A copy of the petition is attached as Exhibit A.

Dated this 17th day of November, 2022.

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## CERTIFICATE OF SERVICE

I hereby certify that on the 17th day of November, 2022, a true and correct copy of the foregoing "Notice of Filing of Writ Petition" was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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# EXHIBIT A

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EXHIBIT A

Case No. _____

# In the Supreme Court of Nevada

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Nov 17 2022 10:43 AM
Elizabeth A. Brown
Clerk of Supreme Court

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,

and

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD.,

Real Parties in Interest.

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## PETITION FOR WRIT OF MANDAMUS OR, ALTERNATIVELY, PROHIBITION

*With Supporting Points and Authorities*

District Court Case No. A-19-792978

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## PETITION FOR WRIT OF MANDAMUS OR, ALTERNATIVELY, PROHIBITION

Petitioners UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. seek a writ of *mandamus* (1) directing the district court to vacate its orders denying petitioners' request to seal certain highly confidential trial documents and related excerpts from the trial transcripts; and (2) enjoining the district court and all parties from disseminating these highly confidential documents to the public. Alternatively, petitioners seek a writ of prohibition to prevent the district court from enforcing its unsealing orders.

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Dated this 15th day of November, 2022.

LEWIS ROCA ROTHGERBER CHRISTIE LLP

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## VERIFICATION

STATE OF NEVADA
COUNTY OF CLARK

Under penalty of perjury, I declare that I am counsel for the petitioners in the foregoing petition and know the contents thereof; that the pleading is true of my own knowledge, except as to those matters stated on information and belief; and that as to such matters I believe them to be true. I, rather than petitioners, make this verification because the relevant facts are procedural and thus within my knowledge as petitioners' attorney. This verification is made pursuant to NRS 15.010.

Dated this 15th day of November, 2022.

*/s/ Daniel F. Polsenberg*
DANIEL F. POLSENBERG

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## NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a), and must be disclosed. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

UnitedHealth Group Incorporated is the parent corporation of Petitioners UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Sierra Health and Life Insurance Company, Inc., and Health Plan of Nevada, Inc. UnitedHealth Group Incorporated is a publicly held company and directly and/or indirectly owns 10% or more of these petitioners' stock.

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Petitioners have been represented by attorneys at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC; Lewis Roca Rothgerber Christie, LLP; and O'Melveny & Myers LLP.

Dated this 15th day of November, 2022.

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## ROUTING STATEMENT

The Supreme Court should retain this petition because the case originated in business court. *See* NRAP 17(a)(9). In addition, the question of whether trade secrets and other confidential information subject to a protective order lose that protection once that information is introduced into evidence at trial—contrary to SRCR 3(4)(b) and (g)—is a question of statewide public importance. *See* NRAP 17(a)(12).

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# TABLE OF CONTENTS

PETITION FOR WRIT OF MANDAMUS OR, ALTERNATIVELY, PROHIBITION ..... i

VERIFICATION ..... ii

NRAP 26.1 DISCLOSURE ..... iii

ROUTING STATMENT ..... iv

TABLE OF CONTENTS ..... v

TABLE OF AUTHORITIES ..... viii

INTRODUCTION ..... 1

PROCEDURAL HISTORY ..... 6

A. TeamHealth Claims United Does Not Pay Reasonable Rates ..... 6

B. Confidential Documents Were Disclosed with a Protective Order Intended to Maintain Confidentiality ..... 7

*1. "Confidential" Documents* ..... 8

*2. "Attorneys' Eyes Only" Documents* ..... 8

*3. The Process for Challenging Confidentiality Designations, Using Confidential Information at Trial, and Returning the Information after Trial* ..... 9

C. TeamHealth Obtains United's Highly Confidential Information ..... 10

D. TeamHealth Misuses United's Confidential Information During Trial ..... 11

E. United Moves to Seal Confidential Documents Following Trial ..... 14

018780

018780



018780

*1. Strategic Business Plans* ..... 15

*2. Highly Confidential Exhibits* ..... 17

F. The District Court Denies United's Motion to Seal ..... 17

*1. January 12, 2022 Oral Ruling* ..... 18

*2. February 10, 2022 Hearing* ..... 20

*3. February 16, 2022 Hearing* ..... 21

*4. Disputes Following February Hearings* ..... 21

*5. District Court's Written Order* ..... 22

*6. District Court's Written Order Unsealing Trial Transcripts* ..... 22

LEGAL ARGUMENT ..... 24

I. WRIT RELIEF IS APPROPRIATE TO PROTECT CONFIDENTIAL INFORMATION ..... 27

II. THE DISTRICT COURT ERRONEOUSLY UNSEALED HIGHLY SENSITIVE PROPRIETARY MATERIALS ..... 30

A. The District Court Erred by Unsealing Information Subject to a Protective Order, Even Though the Information Was Never Discussed in Court ..... 33

B. The District Court Erred by Refusing to Seal Any Page that Was Shown to the Jury at Trial ..... 38

C. The District Court Erred by Refusing to Seal or Redact United's Trade Secrets Based on Misunderstandings of Trade Secret Law ..... 43

*1. United Demonstrated that the Exhibits Were Trade Secrets and TeamHealth Failed to Rebut that Showing* ..... 45




018781

018781

018781

a. UNITED ESTABLISHED THAT THE EXHIBITS SUBJECT TO ITS MOTION ARE TRADE SECRETS THAT SHOULD BE SEALED ..... 46

b. TEAMHEALTH FAILED TO REBUT UNITED'S SHOWING ..... 52

*2. Trade Secrets Can be Developed from Publicly Available Information* ..... 54

*3. Staleness is a Case-Specific Inquiry Not Dependent on the Age of the Information* ..... 58

D. Sealing is Justified Based on the Compelling Circumstances of this Case ..... 62

CONCLUSION ..... 66

CERTIFICATE OF COMPLIANCE ..... xii

CERTIFICATE OF SERVICE ..... xiii

018782

018782



018782

# TABLE OF AUTHORITIES

## Cases

*3M v. Pribyl*,
259 F.3d 587 (7th Cir. 2001) ..... 56

*AirFacts, Inc. v. de Amezaga*,
909 F.3d 84 (4th Cir. 2018) ..... 56

*Archon Corp. v. Eighth Judicial Dist. Court*,
133 Nev. 816, 407 P.3d 702 (2017) ..... 29

*Associated Press v. State*,
888 A.2d 1236 (N.H. 2005) ..... 35

*Bhagat v. Diamond Info. Sys., LLC*,
84 Va. Cir. 233, 2012 WL 7827846 (Va. Cir. 2012) ..... 35, 41

*Brown & Williamson Tobacco Corp. v F.T.C.*,
710 F.2d 1165 (6th Cir. 1983) ..... 36

*Cotter v. Eight Judicial Dist. Court*,
134 Nev. 247, 416 P.3d 228 (2018) ..... 28

*EEOC v. Erection Co.*, Inc.,
900 F.2d 168 (9th Cir. 1990) ..... 32

*In re Elec. Arts, Inc.*,
298 F. App'x 568 (9th Cir. 2008) ..... 41

*Emergency Care Services of Pennsylvania, P.C. et al. v. UnitedHealth Group, Inc., et al.*,
No. 19-01195, ECF No. 1 (M.D.P.A. filed July 11, 2019) ..... 26

*Emergency Group of Arizona Prof'l Corp. v. United Healthcare Inc.*,
No. 19-04687, ECF No. 18 (D. Az. filed Aug. 9, 2019) ..... 26

*Enter. Leasing Co. of Phoenix v. Ehmke*,
3 P.3d 1064 (Ariz. Ct. App. 1999) ..... 56, 59



018783

018783

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*Florida Emergency Physicians et al. v. United Healthcare of Florida, Inc.*,
No. 20-60757, ECF No. 27 (S.D.Fl. filed Mar. 3 2020) ..... 26

*Hagestad v. Tragesser*,
49 F.3d 1430 (9th Cir. 1995) ..... 32

*Howard v. State*,
128 Nev. 736, 291 P.3d 137 (2012) ..... 30, 31

*Hunt v. Zuffa, LLC*,
528 F. Supp. 3d 1180 (D. Nev. 2021) ..... 64

*Imperial Chemical Industries Ltd. v. National Distillers & Chemical Corp.*,
342 F.2d 737 (2d. Cir. 1965) ..... 56

*International Game Tech., Inc. v. Second Judicial Dist. Court*,
124 Nev. 193, 179 P.3d 556 (2008) ..... 28

*JetSmarter Inc. v. Benson*,
2018 WL 2709864 (S.D. Fla. Apr. 6, 2018) ..... 44

*Kamakana v. City & Cty. of Honolulu*,
447 F.3d 1172 (9th Cir. 2006) ..... 63, 64

*Krueger v. Ameriprise Financial, Inc.*,
2014 WL 12597948 (D. Minn. 2014) ..... 36

*State ex rel. Lucas Cty. Bd. of Commrs. v. Ohio Environmental Protection Agency*,
724 N.E.2d 411 (Ohio 2000) ..... 56

*Mallet & Co. Inc. v. Lacayon*,
16 F.4th 364 (3d Cir. 2021) ..... 55

*In re Nat'l Consumer Mortg., LLC*,
512 B.R. 639 (D. Nev. 2014) ..... 16, 25, 37



018784
018784
018784

*Nevada Indep. v. Whitley*,
138 Nev., Adv. Op. 15, 506 P.3d 1037 (2022) ..... 4, 55

*Saini v. Int'l Game Tech.*,
434 F. Supp. 2d 913 (D. Nev. 2006) ..... 44

*San Jose Mercury News, Inc. v. U.S. Dist. Ct.--N. Dist. (San Jose)*,
187 F.3d 1096 (9th Cir. 1999) ..... 31

*Stanislaus Food Products Co. v. USS-POSCO Industries*,
2012 WL 6160468 (E.D. Cal. 2012) ..... 60, 61

*Synergetics, Inc. v. Hurst*,
477 F.3d 949 (8th Cir. 2007) ..... 59

*The Plain Dealer v. Ohio Dept. of Ins.*,
687 N.E.2d 661 (Ohio 1997) ..... 56

*Matter of Tiffee*,
137 Nev. 224, 485 P.3d 1249 (2021) ..... 33, 45

*Uncle B's Bakery, Inc. v. O'Rourke*,
920 F. Supp. 1405 (N.D. Iowa 1996) ..... 44

*United States v. Criden*,
648 F.2d 814 (3d Cir. 1981) ..... 32

*Valley Broad. Co. v. U.S. Dist. Ct. for Dist. of Nev.*,
798 F.2d 1289 (9th Cir. 1986) ..... 32, 45, 63

*Valley Health System, LLC v. Eighth Judicial Dist. Court*,
127 Nev. 167, 252 P.3d 676 (2011) ..... 27

*Zenith Radio Corp. v. Matsushita Elec. Indus. Co.*,
529 F. Supp. 866 (E.D. Pa. 1981) ..... 44

**Rules**

NRCP 26(c) ..... 25, 33

SRCR 1(4) ..... 40



018785

018785

018785

SRCR 2(2) ..... 40

SRCR 3(4) ..... 4, 5, 30, 31, 38, 41

SRCR 3(4)(b) ..... 25, 33

SRCR 3(4)(g) ..... 3, 25, 43, 45

SRCR 3(4)(h) ..... 26, 62

**Statutes**

NRS 600A.030(5) ..... 25, 45, 51, 52

NRS 600A.030(5)(a) ..... 56

NRS 600A *et seq.* ..... 43, 45

**Regulations**

17 CFR 243.100 ..... 47

17 CFR 243.101 ..... 47

17 CFR 243.102 ..... 47

17 CFR 243.103 ..... 47

**Treatises**

76 C.J.S. Records § 82 ..... 63

**Other Authorities**

*Protecting our Healthcare Heroes,* TEAMHealth (last visited November 4, 2022), https://www.teamhealth.com/protectingourhealthcareheroes/nevada/?r=1 ..... 14

Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 Am. J.L. 7 Med. 243, 262 (2012) ..... 46



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## INTRODUCTION

This petition arises out of a dispute over the lawful rates of reimbursement for medical services provided to members of employee health benefit plans insured and/or administered by affiliates of petitioner UnitedHealthcare Insurance Company (collectively, "United"). Such plans typically employ two mechanisms to cover or defray the costs of medical care for plan members. One mechanism is payment for services provided by "network" providers, i.e., providers who are subject to contractual agreements with United to provide specified services at specified rates to members of United-administered plans. The other mechanism is payment for services provided by "out-of-network" providers, i.e., providers that lack any contractual relationship with United. With respect to out-of-network providers, United's customers select out-of-network reimbursement methodologies that are then implemented as part of the plans. The dispute underlying this appeal involves an effort by TeamHealth—a staffing entity that negotiates with plans on behalf of medical providers—to compel United to pay out-of-network providers more than what is required by the plans themselves.

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This petition involves an issue ancillary to that underlying substantive dispute. During discovery, United was forced to produce to TeamHealth (sometimes only to its counsel) extensive, proprietary, highly-confidential trade secrets and other business information United generated and used to develop its provider networks and negotiate reimbursement rates around the country. The information was produced subject to a protective order that explicitly governed not just discovery, but also trial and the *post*-trial disposition of the material, to ensure that United's competitors and business partners (existing and potential) could not use United's data to gain a competitive edge or bargaining advantage over United.

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Although the protective order expressly provided that all material within its scope would be returned or destroyed after trial, the district court reneged on that promise and refused to seal or redact many trial exhibits containing United's most valuable and confidential commercial information. The overwhelming majority of this information was not even shown to or discussed before the jury.

Under settled Nevada law, such commercially sensitive information should be redacted from the publicly disclosed record.



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Nevada law provides clear and specific standards to govern the sealing of court records—including trial exhibits and testimony—as needed to preserve legitimate private interests while preserving the public interest in access to court proceedings. The district court's post-trial sealing rulings often failed to apply those standards at all, on the stated—but demonstrably incorrect—premise that trial exhibits and testimony are categorically public record. And to the extent the court considered the sealing standards, it applied them incorrectly.

One of the key issues in the sealing inquiry was whether information—most of it not shown to the jury—constituted trade secrets, which are exempt from disclosure under Nevada rules governing disclosure of court records. SRCR 3(4)(g) (authorizing "sealing or redaction" when "necessary to protect intellectual proprietary or property interests such as trade secrets as defined in NRS 600A.030(5)"). In determining what information should remain protected as trade secret, the district court misconstrued the controlling standards in two respects. First, the court held that a business cannot claim trade secret status in a compilation of information gathered from public sources. This Court recently held exactly the opposite, *see*

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*Nevada Indep. v. Whitley*, 138 Nev., Adv. Op. 15, 506 P.3d 1037, 1045 (2022), as have many courts in other jurisdictions, *see infra* at Section II.C(2). Second, the district court rejected trade secret status for some information based solely on the age of the data, without analyzing whether the information had continuing value, as the law unambiguously requires. This Court should either grant the writ and apply the proper trade secret standards, or correct the district court's misunderstanding of those standards and direct the district court to conduct a proper review of the exhibits.

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In addition to ignoring or misapplying settled trade secret law, the district court ignored or misapplied other recognized standards for protecting information from disclosure when the "public interest in privacy or safety interests . . . outweigh[s] the public interest in open court records." SRCR 3(4). Under Nevada law, privacy interests prevail not only when information qualifies as a trade secret, but also when "(a) [t]he sealing or redaction is permitted or required by federal or state law," or "(b) [t]he sealing or redaction furthers . . . a protective order entered under NRCP 26(c)," or "(h) [t]he sealing or redaction is justified or required by another identified compelling circumstance."

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SRCR 3(4). The district court here did not even consider the existing protective order, which United relied on in acquiescing to limited disclosures as needed to facilitate an orderly trial proceeding. Nor did the court properly consider whether United's interest in protecting commercially valuable information—regardless of its trade secret status—presented a compelling circumstance justifying redaction, especially given that the information at issue was not even shown to or discussed before the jury.

United obviously would be prejudiced by disclosure of its commercially sensitive information. Its competitors would be gifted a deep understanding of its business objectives and strategies for execution, allowing them to develop responses and counter-strategies. And business partners likewise could and would use United's information to increase their bargaining leverage in negotiations. Such severe and irreversible harm is precisely the reason Nevada law recognizes that the public interest in privacy sometimes outweighs the public interest in disclosure of court records. Especially where, as here, the information at issue actually had little if any relevance to the proceeding, the information can and should continue to be protected

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from public disclosure.

United therefore requests that the Court issue a writ of mandamus or prohibition directing the district court to seal these confidential trial exhibits and enjoining the parties from publishing them. At a minimum, this Court should vacate the district court's order and direct the district court to apply the correct legal analysis to United's motion to seal.

## PROCEDURAL HISTORY

### A. TeamHealth Claims United Does Not Pay Reasonable Rates

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Petitioners/defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (collectively "United") are entities that insure and/or administer health benefit plans that cover all or part of plan members' medical expenses. Such plans generally provide one payment rate for medical care provided by "network" providers—i.e., providers that have contracted with United to provide care at specified rates—and a lower payment rate for care provided by "out-of-network" providers that have no contract with United.



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Real parties-in-interest/plaintiffs Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; and Crum Stefanko and Jones, Ltd. (collectively "TeamHealth") are staffing companies that supply professional staffing to hospital emergency rooms in Nevada.

TeamHealth is not in United's network, so the parties do not have agreed rates of reimbursement. Rather, United pays TeamHealth in accordance with the payment promised to plan members for out-of-network services. In the underlying litigation, TeamHealth claimed that United's plan benefit for out-of-network services did not result in reasonable reimbursement to providers for their services, and that United owed providers the difference between the plan benefit and the amount deemed legally reasonable.

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### B. Confidential Documents Were Disclosed with a Protective Order Intended to Maintain Confidentiality

On June 24, 2020, the parties stipulated to, and the district court entered, a protective order to maintain the confidentiality of trade secrets and other business information during the litigation and discovery. (1 App. 1.) The protective order allowed the parties to



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designate certain disclosed documents either "Confidential" or "Attorneys' Eyes Only."

### *1. "Confidential" Documents*

Under the protective order, a party could designate a document as "Confidential" if that party

> reasonably and in good faith believes [the document] contains or reflects: (a) proprietary, business sensitive, or confidential information; (b) information that should otherwise be subject to confidential treatment pursuant to applicable federal and/or state law; or (c) Protected Health Information, Patient Identifying Information, or other HIPAA-governed information.

(1 App. 5 at §2(a).)

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Information designated "Confidential" may not be shared outside the litigation but may be shared with a party's employees and officers. (1 App. 11 at ¶ 10(c).)

### *2. "Attorneys' Eyes Only" Documents*

The protective order also allowed a party to designate documents as "Attorneys' Eyes Only" ("AEO") if it contained information the party

> reasonably and in good faith believes contains trade secrets or is such highly competitive or commercially sensitive proprietary and non-public information that would significantly harm business advantages of [the party] … and that disclosure of such information could reasonably be expected to be detrimental to the



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[party's] interests.

(1 App. 6 at §2(b).)

Because "AEO" information is more sensitive, these documents can only be shared with a party's outside lawyers and two specifically designated in-house counsel not involved in rate negotiations. (1 App. 11 at ¶ 11(d).) AEO information cannot even be shared with a party's employees and officers. (*Id.*)

### *3. The Process for Challenging Confidentiality Designations, Using Confidential Information at Trial, and Returning the Information after Trial*

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The protective order sets forth a specific process for challenging confidentiality designations. (1 App. 9-10 at ¶ 9.)

Trial would not obviate this process. If unchallenged, confidential information would retain protection through trial. (1 App. 15-16 at ¶ 20.) In fact, jurors were "Qualified Persons" entitled to view the confidential information. (1 App. 11 at ¶ 12(a).) The order further authorized the district court to "take such measures, as it deems appropriate, to protect the claimed confidential nature of the document or information sought to be admitted and to protect the Confidential Information from disclosure." (1 App. 15 at ¶ 20.)



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Finally, the order provided that all such information must be returned to the producing party or destroyed at the end of the litigation. (1 App. 13-14 at ¶ 14.) Nowhere did the order state or contemplate that protected information instead would be freely disclosed to the public after trial, which would moot all efforts to protect the information during discovery and trial.

### C. TeamHealth Obtains United's Highly Confidential Information

In discovery, TeamHealth obtained United documents that contain highly sensitive, proprietary, and confidential information, including information not related to the parties' relationship or the parties' relationship in Nevada. Many of those documents were barely, if at all, relevant to TeamHealth's allegations, but happen to be crucial to United's overall business strategies. For example, TeamHealth obtained United's business plans, rate structures with other providers, revenue for all products, product strategy information, network negotiating strategies, and United's contracts with customers. (17 App. 3885, 3906–30.) These documents include large swaths of information that have little or no relevance to the core issue of this case—the reasonableness of United's reimbursement rates—but are among the



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most sensitive confidential information United possesses. United has consistently maintained that public disclosure of such information advances no case-related interest and would irreparably harm their business interests.

As to the documents that are the focus of this petition, TeamHealth never invoked the established process for challenging United's confidentiality designations. United therefore understood that the procedures in the protective order for keeping its information confidential would be followed at trial.

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### D. TeamHealth Misuses United's Confidential Information During Trial

Just before trial, two media organizations requested to broadcast the trial. (1 App. 52–68.) United asserted a limited objection, requesting that the district court impose restrictions on media coverage to ensure that AEO information—the most sensitive information—was not disclosed to the public in violation of the protective order. (1 App. 69-104.) TeamHealth responded to the objection in favor of the media request, and proposed as a "practical and reasonable" alternative that TeamHealth would "not oppose any post-trial motions to seal the documentary evidence that comes into trial," thereby "allow[ing] United



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to maintain confidentiality over its documents while also protecting Nevada's open courts." (1 App. 112:18-22). Under TeamHealth's proposal, "testimony would be public," but "the documents themselves would not be, which would significantly mitigate any of United's alleged harm." TeamHealth did not want to interrupt the trial by sealing the courtroom. (1 App. 112:22-23.)

During a break from jury selection, while considering United's limited objection to the media request, the district court first suggested that it would not seal any evidence that was admitted in the trial: "I can tell you right now that I will not seal anything that's admitted. It's not going to happen." (1 App. 236:5-6.); (1 App. 237:17-18) ("I can tell you I won't seal any exhibit that gets admitted. I think I made that clear."); (1 App. 240:2-4 ("But if . . . it gets admitted it's in the public domain."). Nonetheless, the court agreed to take AEO information on a "piecemeal basis." (1 App. 236:3-8; 239:12-13.) The court further ordered that the parties confer regarding the process for dealing with United's objections to AEO material at trial. (1 App. 239:10-13; 240:10.) The parties ultimately agreed that United could redact portions of AEO documents shown at trial and that the livestream would not broadcast when AEO

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documents were referenced. The parties further agreed, so as not to delay or disrupt trial with argument about every AEO document, United could file a motion to seal after the trial. (5 App. 1017:2-24.)

TeamHealth later published 18 AEO admitted exhibits on its public website during the middle of trial. (5 App. 1017:2-24; 17 App. 3891.)

The ripple effect was immediate. Bonds of a third-party company Multiplan, Inc.., which is a vendor that contracts with United, "tumbled" by 6.3 points after one of the documents revealed that United had considered terminating certain contracts with Multiplan by 2023. (17 App. 3932.) Barclays reported that "[b]ased on the [United] strategy document, the plan from [United] may be to exit the [Multiplan] contract" and "the potential loss of [United] as a customer would be a major negative for [Multiplan.]" (17 App. 3934.) The leaked document actually resulted in Barclays lowering its estimated value of Multiplan's stock price. (17 App. 3934; *see also* 17 App. 3946 (showing a steep decline in Multiplan's stock price around the date TeamHealth disclosed United's protected AEO documents).)

When the district court learned that TeamHealth posted the AEO



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documents on TeamHealth's website, the district court ordered TeamHealth to "take them down" and explained that all exhibits and transcripts were "locked" during trial. (*See e.g.* 5 App. 1017:21; 7 App. 1693:20-22; 8 App. 1790:9-12.) The parties and district court clearly understood that United's intent was to address confidentiality issues in a motion to seal after trial. (7 App. 1727:14-25; 1728:1-7.)

Following the district court's ruling to take down the leaked documents, TeamHealth's website now reads, "At the conclusion of the trial, the trial exhibits will be made available on this site subject to any limiting orders of the court." *Protecting our Healthcare Heroes,* TEAMHealth (last visited November 4, 2022), https://www.teamhealth.com/protectingourhealthcareheroes/nevada/?r=1.

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There is much more damage to be done if TeamHealth gets its wish to publish information contained within exhibits admitted at trial.

### E. United Moves to Seal Confidential Documents Following Trial

The protective order, under which all of these documents were disclosed and later admitted at trial, contemplated that disclosed documents would be filed under seal. (1 App. 15–16 at ¶ 20.) Following



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trial, and consistent with the protective order, United filed a Motion to Seal Certain Confidential Trial Exhibits on December 13, 2021. (17 App. 3883.) Still, cognizant of Nevada's policy favoring public access to court records, United requested that the district court seal (or redact) only a limited subset of admitted exhibits that fell into two categories: strategic business plans and highly confidential information.

### *1. Strategic Business Plans*

The first category, identified in Exhibit A to the motion to seal, includes strategic business plans, forecasts, and other confidential, trade secret, proprietary, and commercially sensitive information. (17 App. 3906–30.) Disclosure of this information would be a gift to United's competitors, and would irreparably harm United if made public. These strategic-business-plans exhibits include a 2020 business plan for a core business division (PX 447), which reveals (1) a current financial plan[1] (P447.0004, P447.0021-25); (2) current strategic priorities (P447.0005); and (3) a current 3 to 5-year growth plan

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[1] Although the district court partially granted the motion to seal the numbers included in the plan on page 4, the district court denied sealing various written descriptions of the plan.



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(P447.0017)—crown jewels that any competitor, to United's irreparable detriment, would benefit from seeing. (17 App. 3887, 29 App. 6998, 7001, 7002, 7014, 7018–22.) These documents also include a 2020 internal presentation disclosing United's internal profit targets for that division for the years 2021-2026 (P273.0003). (17 App. 3887, 25 App. 6001, 6004, 26 App. 6187, 6195–97.)

In most instances, the jury was only shown a handful of pages of these strategic business plans. The public interest in open court proceedings has little if any application to the portions of these documents that were not even shown to the jury, and whatever public interest there is cannot possibly outweigh the impact their disclosure would have on United. *See In re Nat'l Consumer Mortg., LLC*, 512 B.R. 639, 641 (D. Nev. 2014) (in evaluating whether to keep exhibits under seal, distinguishing between exhibits published and not published to the jury). Accordingly, given the sensitivity of these exhibits, United moved the district court to seal the pages of the strategic business plans that were not shown to the jury, and to redact the financially sensitive information that was in fact shown to the jury.

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### *2. Highly Confidential Exhibits*

The second category of trial exhibits, identified in Exhibit B to the motion to seal, includes highly confidential, proprietary, and commercially sensitive financial figures and strategic information, as well as protected health information and personal identifiable information. (17 App. 3914–30.) For this category of confidential information, United sought a limited remedy of redacting only the discrete line items containing the confidential information. In various other documents, United did not argue that the entire document or page should remain sealed, but instead that specific numerical values that are highly sensitive be redacted before public disclosure.

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## F. <u>The District Court Denies United's Motion to Seal</u>

Reneging on its prior commitments (1 App. 1), TeamHealth opposed United's motion to seal and sought full public disclosure of all trial exhibits. (12 App. 2985.) The district court heard and orally denied United's motion on January 12, 2022. Ignoring its own protective order, the Rules Governing Sealing and Redacting of Court Records ("SRCR"), and this Court's precedent, the district court ordered disclosure of large swaths of sensitive propriety and other financial



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information subject to the protective order. In large part, the district court followed the categorical position it announced earlier in the trial that any admitted exhibit—regardless of its contents, and regardless of confidentiality measures taken during trial—would become a public document after trial was over.

### *1. January 12, 2022 Oral Ruling*

The district court's brief oral ruling at the January 12, 2022 hearing can be read in full at 31 App. 7493:13–7495:7. The district court began by positing—without any supporting evidence—that the insurance industry is "highly regulated," "very competitive," "[t]he business models are all almost identical," and "the defendant is a publicly-traded company." (31 App. 7493:17-20.) The Court then declared that "[t]he strategies here for any business is to provide value for its customers and success for its shareholders" and that insurance companies "know a lot more about each other" and "[t]hey learn those metrics" and the business models and metrics are identical. (31 App. 7493:21-25.)

As for legal standards, the district court acknowledged Nevada's policy in favor of "least restrictive means" and declared "I have to make

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findings in order to seal or redact things." (31 App. 7494:2-4.) The court went on to say, "And I can only do it for personal information, medical records, trade secrets, or when it's justified – which gives me some discretion." (31 App. 7494:4-6.)

The court denied "the motion in the most part" but did "grant it in a few areas." (31 App. 7494:7-8.) The court went on to list categories in which the motion to seal was granted and categories in which the motion was denied. For example, the motion was "granted with regard to the [Mergers and Acquisitions] targets" and "individual medical data." (31 App. 7494:9-14.) But was denied "with regard to reimbursement rates" and "anything that was publicly disclosed, which include[d] anything used in opening or closing or used at trial." (31 App. 7494:15-21.)

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After setting forth the rulings, which did not include any analysis or weighing of interests, the district court said, "that should give you some direction, but I assume there will be some question marks." (31 App. 7495:2-4.) Over the next several months, the district court left it to the parties to glean its analysis from the January 12, 2022 hearing and attempt to apply its rulings to individual documents. ((31 App.



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7495:3-6) (court discussing a follow-up hearing to "hash out specifics" after the parties have "a chance to digest all of it").)

### *2. February 10, 2022 Hearing*

The first substantive hearing following the oral ruling on the motion to seal was on February 10, 2022.[2] At that hearing, the district court denied United's request for an evidentiary hearing to present testimony further establishing the trade secret and confidential nature of the exhibits the court would be addressing. (32 App. 7580–85.) At the hearing, the district court mostly refused to clarify or elaborate on its prior oral ruling. (*See* 32 App. 7629–39.) When the court did address a specific document, it primarily just said whether the motion to seal was either granted or denied without giving any explanation. On some occasions, however, the district court did state that it was denying the motion to seal because the information somehow related to a topic at trial. [*See, e.g.*, 32 App. 7651:1-2 ("denied for the reason that the jury

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[2] The parties did attend hearings on January 20, 2022 and January 27, 2022 that involved sealing. (31 App. 7500, 7554.) The January 20, 2022 hearing was on the motion of a non-party (Multiplan) to seal, which overlapped with United's motion to seal and also discussed compilations of data, staleness, and burden of proof.



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saw this page"), 7662:22-23 ("all of this information came out during the trial"); 7665:1-2 ("all of this came up at the time of trial").] This further underscored that the district court's principal standard for unsealing documents was simply whether they were "used at trial." (31 App. 7494:15-21.)

### *3. February 16, 2022 Hearing*

The next hearing, on February 16, 2022, was similar. Almost all of the court's ruling consisted of summary denials or grants. When the court occasionally did give a reason for denying a request, it was usually on the basis that the information was stale, or it was obtained from public data. (*See, e.g.*, 32 App. 7738:4-5 ("It's just stale information . . . ."); 7762:20-23 ("I just don't see where information from a consultant obtained from public data could be a trade secret."), 7767:5-6 ("it is – really is a compilation of data").]

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### *4. Disputes Following February Hearings*

The parties again worked together to attempt to apply the court's rulings to specific documents, and, on March 4, 2022, submitted a joint status report detailing the remaining disputes. [Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in



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Dispute.] The joint status report included written arguments from each party regarding disputed redactions.

### *5. District Court's Written Order*

The district court entered its written order on October 10, 2022. (15 App. 3663.) The appendix attached to the written order includes a document-by-document and page-by-page breakdown of the court's rulings on the motion to seal. The district court stayed execution of the order for thirty days for United to seek review in this Court.

### *6. District Court's Written Order Unsealing Trial Transcripts*

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United also moved to redact ten numerical figures appearing on just five pages of the trial transcripts. (13 App. 3151.) Those figures identify internal operating income ("IOI"), which is highly sensitive and non-public financial data reflecting the performance of particular United programs and units. Two witnesses testified to IOI figures that were in documents that had been marked Attorneys' Eyes Only or Confidential when produced by United and that were subject to the motion to seal. (13 App. 3158.)

The former vice president for out-of-network programs testified



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about a projection of the amount of money in the aggregate that United could save their self-insured employer clients by 2023. (17 App. 3821:6–3822:7.) Another witness testified via prior deposition testimony regarding IOI of shared savings programs from 2016 to 2019. (17 App. 3879:22–3881:7.) If these numbers are released to the public at large, they will place United at a disadvantage both in competition in the marketplace on affordability initiatives as well as in negotiations with clients, because United's competitors and clients will be armed with knowledge of United's internal financial data and projections.

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The district court denied the motion to redact portions of the trial transcript, finding that the IOI figures were not entitled to protection under the court's previous order granting in part and denying in part the defendants' motion to seal certain confidential trial exhibits. (15 App. 3653–54.) The court stayed execution of the order for thirty days for United to seek review from this Court.

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United appealed and moved to extend the stay. (13 App. 3177; Docket No. 85525, Doc. No. 22-33964.) This Court entered a temporary stay of the district court orders pending the completion of briefing on the stay motion and further order of this Court. (16 App. 3718A–B.)



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## LEGAL ARGUMENT

This is the quintessential civil business case for writ relief and the application of settled rules allowing courts to seal trial records. TeamHealth proposed as trial exhibits some of United's most commercially sensitive documents, which included confidential plans for future business and commercial relationships, financial projections that could move markets, and other documents reflecting highly sensitive strategic decision-making. Despite admitting the entirety of these exhibits, TeamHealth only used a handful of pages during its witness examinations and therefore only published a limited number of pages to the jury. Some exhibits were never published during the trial presentation at all. If the otherwise-confidential information was not important enough to actually use at trial, there is no compelling reason for disclosing it as part of the public trial record now.

The fact that TeamHealth did not even rely on the information in the documents at trial shows that TeamHealth's efforts to unseal those documents has more to do with disrupting United's business than it does with preserving the record of a trial regarding rates of reimbursement. United's interest in keeping this extremely sensitive



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information under seal greatly outweighs any possible public interest in its wholesale disclosure—and most certainly outweighs TeamHealth's inappropriate private interest in harming United's business. *See In re Nat'l Consumer Mortg., LLC*, 512 B.R. at 641 (holding that trial exhibits containing a proprietary algorithm should remain sealed as a trade secret, as "the public's right to know this information as part of a court record is low").

United satisfied the requirements for maintaining the confidentiality of these trial exhibits and has a compelling interest in maintaining the exhibits under seal. Nevada law provides multiple separate bases by which the district court should have granted these limited and targeted requests to seal the trial record:

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First, a post-trial order to seal was proper to enforce the original protective order entered pursuant to NRCP 26(c). *See* SRCR 3(4)(b). Yet the district court's ruling completely ignored the valid protective order as a ground for continued sealing. (*See* 31 App. 7494:2-6.)

Second, sealing (including redaction) is necessary to protect United's property interests, such as trade secrets, as defined by NRS 600A.030(5). SRCR 3(4)(g). United's strategic business plans, by their



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very nature, contain highly competitive and commercially sensitive proprietary and non-public information that would significantly harm United's business advantages if made public. The district court misunderstood what a trade secret is, erroneously concluding that information became stale based solely on the year it was created, without acknowledging the continued need for confidentiality, and that compilations of publicly available information cannot constitute trade secrets as a matter of law.

And third, sealing (including redaction) is justified for the independent reason that TeamHealth has no legitimate need to disclose United's proprietary information. TeamHealth seeks to disclose this information solely to impact other similar cases in other states and to exert business pressure on defendants. SRCR 3(4)(h).[3] The district

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[3] *See e.g.*, *Emergency Care Services of Pennsylvania, P.C. et al. v. UnitedHealth Group, Inc., et al.*, No. 19-01195, ECF No. 1 (M.D.P.A. filed July 11, 2019); *Emergency Group of Arizona Prof'l Corp. v. United Healthcare Inc.*, No. 19-04687, ECF No. 18 (D. Az. filed Aug. 9, 2019); *Buffalo Emergency Associates, LLP, et al. v. UnitedHealth Group, Inc., et al.*, No. 19-01148, ECF No. 1 (W.D.N.Y. filed Aug. 26, 2019); *Florida Emergency Physicians et al. v. United Healthcare of Florida, Inc.*, No. 20-60757, ECF No. 27 (S.D.Fl. filed Mar. 3 2020); *United HealthCare Services, Inc. et al. v. Team Health Holdings, Inc. et al.*, No: 3:21-cv-00364, ECF No. 1 (E.D.TN., filed Oct. 27, 2021).



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court abused its discretion by allowing the judicial processes of this State to be misused for such private, extrajudicial objectives.

United's proposed handling of these confidential documents struck the right balance between allowing public access to the trial record on the one hand and protecting sensitive commercial information on the other. United primarily urged the district court to seal or redact the portions of strategic business plans that were never shown to the jury or discussed with a witness. And for the few highly confidential exhibits that were actually discussed at trial and shown to the jury, United proposed that the redactions be limited to the discrete sensitive financial figures, strategy, personal health information, or personal identifiable information in the exhibit. The district court should have adopted that modest, balanced approach.

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## I.

## WRIT RELIEF IS APPROPRIATE TO PROTECT CONFIDENTIAL INFORMATION

Writ relief is a proper remedy to preserve the confidentiality of documents that have been improperly ordered disclosed by a district court. *See, e.g.*, *Valley Health System, LLC v. Eighth Judicial Dist.*



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*Court*, 127 Nev. 167, 169, 252 P.3d 676, 677 (2011) (recognizing that "a writ petition is the proper mechanism to seek relief" under circumstances where "once information is produced, any privilege applicable to that information cannot be restored"). In the absence of the relief requested in this writ petition, United will be irreparably harmed by the disclosure of its most sensitive strategic business plans and confidential information into the public domain. *See Cotter v. Eight Judicial Dist. Court*, 134 Nev. 247, 249, 416 P.3d 228, 231 (2018) (granting writ relief where "without writ relief, compelled disclosure . . . [would] occur and petitioner would have no effective remedy, even by subsequent appeal"). This petition also raises an issue of statewide importance, which is whether all highly confidential information within documents admitted at trial necessarily must be publicly disclosed after trial merely because the document was admitted into evidence. *See International Game Tech., Inc. v. Second Judicial Dist. Court*, 124 Nev. 193, 198, 179 P.3d 556, 559 (2008) (granting review when the "petition raises an important legal issue in need of clarification, involving public policy, of which this court's review would promote sound judicial economy and administration"). United submits that no such categorical

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disclosure rule does or should exist. Instead, the district court must weigh and balance the recognized factors governing the use of confidential information at trial. To permit otherwise could encourage litigants to exploit the Nevada court system to harm competitors by forcing disclosure of their sensitive business information without genuine public need or benefit.

Relief is appropriate when the district court "committed 'clear and indisputable' legal error . . . or an 'arbitrary or capricious' abuse of discretion." *Archon Corp. v. Eighth Judicial Dist. Court*, 133 Nev. 816, 819-20, 407 P.3d 702, 706 (2017) (internal quotations omitted). The district court here did both. It committed the inarguable legal error of holding that merely admitting a document at trial mandates public disclosure of its contents, no matter how sensitive. And it abused its discretion both by making that legal error and by failing to properly balance the factors that govern motions to seal confidential information. Because writ relief is the only remedy available to United to challenge the district court's order,[4] United asks this Court to grant it the

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[4] United filed a notice of appeal on October 12, 2022, which includes the sealing orders regarding trial exhibits and trial transcripts. (13 App. 3177.) *See* Docket No. 85525. United believes that the orders are



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extraordinary remedy of a writ of mandamus, or in the alternative, prohibition.

## II.

## THE DISTRICT COURT ERRONEOUSLY UNSEALED HIGHLY SENSITIVE PROPRIETARY MATERIALS

Nevada law does not recognize a categorical rule that all trial exhibits automatically become public record. To the contrary, "[a]lthough public access is favored, it is not unfettered." *Howard v. State*, 128 Nev. 736, 740, 291 P.3d 137, 140 (2012). In fact, the Nevada Rules for Sealing and Redacting Court Records set forth specific standards for determining when trial exhibits should be sealed. These rules would be meaningless if all exhibits were subject to automatic disclosure. *See* SRCR 3(4). The rules instead prescribe a balancing test, which requires a court to seal or redact trial exhibits when a competing interest outweighs the public interest in access to open court

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appealable as they are incorporated into the final judgment, which itself became appealable only after the entry of the last order denying post-judgment relief. United nonetheless submits this petition for extraordinary relief out of an abundance of caution to ensure that the exhibits and transcripts are not unsealed to the public in the event that this Court dismisses United's appeal.



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records. *Id*. at 742, 291 P.3d at 141.

The rules describe how to weigh the public interest in privacy against the public interest in open access to court records. Under SRCR 3(4), a court may order that court records be redacted or sealed provided that "the court makes and enters written findings that the specific sealing or redaction is justified by identified compelling privacy or safety interests that outweigh the public interest in access to the court records." SRCR 3(4). "The public interest in privacy or safety interests that outweigh the public interest in open court records include" when "(a) [t]he sealing or redaction is permitted or required by federal or state law," or "(b) [t]he sealing or redaction furthers . . . a protective order entered under NRCP 26(c)," or "(g) [t]he sealing or redaction is necessary to protect intellectual proprietary or property interests such as trade secrets as defined in NRS 600A.030(5); or (h) [t]he sealing or redaction is justified or required by another identified compelling circumstance." SRCR 3(4).

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When a trial exhibit implicates such competing interests, courts must weigh the relevant interests to determine if disclosure is required. *See San Jose Mercury News, Inc. v. U.S. Dist. Ct.--N. Dist. (San Jose)*,



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187 F.3d 1096, 1102 (9th Cir. 1999). In *Valley Broadcasting*, for example, the Ninth Circuit addressed whether trial exhibits should be disclosed to a television station. *Valley Broad. Co. v. U.S. Dist. Ct. for Dist. of Nev.*, 798 F.2d 1289 (9th Cir. 1986). The court listed several factors "[c]ounseling against" public disclosure, noting in particular "the likelihood of improper use, 'including the publication of scandalous, libelous, pornographic, or trade secret materials; infringement of fair trial rights of the defendants or third persons; and residual privacy rights.'" *Id.* at 1294 (citing *United States v. Criden*, 648 F.2d 814, 830 (3d Cir. 1981)); s*ee also Hagestad v. Tragesser*, 49 F.3d 1430, 1434 (9th Cir. 1995) ("The factors relevant to a determination of whether the strong presumption of access is overcome include the 'public interest in understanding the judicial process and whether disclosure of the material could result in improper use of the material for scandalous or libelous purposes or infringement upon trade secrets.'") (citing *EEOC v. Erection Co.*, Inc., 900 F.2d 168, 170 (9th Cir. 1990)).

Each of United's narrow requests to seal limited information fall within at least one of the categories enumerated in Nevada's Rules Governing Sealing and Redacting Court Records. The district court



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accordingly committed clear legal error and manifestly abused its discretion by mandating disclosure of the information without considering the competing privacy interest.

### A. The District Court Erred by Unsealing Information Subject to a Protective Order, Even Though the Information Was Never Discussed in Court

"A district court abuses its record sealing discretion when it commits legal error." *Matter of Tiffee*, 137 Nev. 224, 225, 485 P.3d 1249, 1251 (2021). Under the Rules Governing Sealing and Redacting Court Records, the public interest in privacy outweighs the public interest in access to a given document when sealing or redacting the document would further a protective order properly entered under NRCP 26(c). SRCR 3(4)(b). The district court abused its discretion and committed legal error by failing to properly consider SRCR 3(4)(b) as a ground for sealing United's confidential information.

Every one of the documents in United's motion to seal remained subject to the protective order at the time of trial. United produced its confidential documents before trial, and handled those documents at trial with the understanding that they remained subject to the protective order. (1 App. 5, at ¶ 1 ("The parties may, however, produce



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certain Confidential Information subject to the terms of this agreement.”).) The protections afforded by the protective order were specifically intended to continue through trial to the conclusion of the matter, after which the protected documents would be destroyed in the normal course. (1 App. 15–16, at ¶ 20 (providing that at trial “[t]he Court may take such measures, as it deems appropriate, to protect the claimed confidential nature of the document or information sought to be admitted and to protect the Confidential Information from disclosure to persons other than those identified” in the protective order).) Indeed, the protective order explicitly included “jurors” as qualified persons to view confidential and attorneys’ only information, demonstrating that the protective order itself contemplated both that it would govern the use of information through trial and that such information would not be disclosed merely because jurors reviewed it. (1 App. 11:23.)

Maintaining the information at issue as confidential, as United requested in its motion to seal, would have adhered to the already-agreed-upon rules established by the protective order. Doing so also would have signaled more broadly that parties in other cases can properly rely on protective orders when they act in good faith to produce



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extremely sensitive documents in litigation, knowing they may do so without fear that those documents will be exploited by the opposing party for private objectives unconnected to the merits of the case. *See Bhagat v. Diamond Info. Sys., LLC*, 84 Va. Cir. 233, 2012 WL 7827846 (Va. Cir. 2012) (sealing trial exhibits to further a protective order because trial exhibits contained "sensitive cost information that competitors could evaluate if made public available" and public disclosure would "benefit [defendant's] competitors at its expense").

Despite the strong privacy interests underlying the protective order, the district court effectively allowed TeamHealth to use the trial process to wash documents and information clean from the protective order, even when lacking probative value to the case. In fact, the majority of the information in the trial exhibits subject to the protective order was never presented to the jury or discussed in front of the jury.

As TeamHealth itself has asserted, the public interest in open access to court records is meant to help the public understand the jury's verdict. (31 App. 7441:9-11, 7482:6-8.) *Cf., e.g.*, *Associated Press v. State*, 888 A.2d 1236, 1244 (N.H. 2005) (recognizing the public interest in access to court documents because "court documents often provide



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important, sometimes the only, bases or explanations for a court's decision") (quoting *Brown & Williamson Tobacco Corp. v F.T.C.*, 710 F.2d 1165, 1177 (6th Cir. 1983)). But when information within an exhibit is not actually presented in court or discussed before the jury, that information almost certainly had little or no relevance to the jury's verdict, especially when 7,285 pages of documents were introduced into evidence at trial. Even though the exhibit itself was deemed relevant and admissible because of information that *was* presented and discussed, the public has no meaningful interest in ancillary information within the document the proffering party did not deem worthy of emphasis. *Cf. e.g.*, *Krueger v. Ameriprise Financial, Inc.*, 2014 WL 12597948 (D. Minn. 2014) (collecting cases for proposition that "only those documents that are relevant to and integrally involved in the resolution of the merits of a case are judicial records to which the presumption of public access attaches"). Simply put, if the information was not important enough for TeamHealth to discuss it with the jury, then it cannot be helpful to understand the jury's verdict.

Accordingly, the portions of exhibits that were not shown to the jury or discussed in open court should have been sealed in furtherance



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of the protective order, because there is no meaningful competing public interest in the disclosure of information or pages of exhibits that were not actually shown to the jury at trial. *Cf. In re National Consumer Mortg., LLC*, 512 B.R. 639 (D. Nev. 2014) (Judge Phillip Pro) (sealing exhibits because they were trade secrets and irrelevant to the case, "and thus the public's right to know this information as part of a court record is low"). Any minimal public interest in such information certainly did not outweigh the strong privacy interests underlying the protective order. As a result, this Court should direct the district court to seal any portion of any trial exhibit that was subject to the protective order and was not discussed with or shown to the jury at trial.

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At a minimum, this Court should order the district court to conduct the proper legal analysis in the first instance. That is, the district court must consider whether United's interest in furthering the protective order outweighs the public interest in access to information in trial exhibits when that information was not discussed with or shown to the jury at trial. The district court never performed this analysis. Instead, the district court's oral ruling, which provides the court's only purported reasoning in regard to the motion to seal, failed to even



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recognize that furthering a protective order was a basis for sealing the trial records. (*See* 31 App. 7494:4-6] ("I can only do it for personal information, medical records, trade secrets, or when it's justified – which gives me some discretion."). Accordingly, the district court's failure to consider or weigh United's interest in furthering the protective order was clear legal error that must be corrected.

### B. The District Court Erred by Refusing to Seal Any Page that Was Shown to the Jury at Trial

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The district court also erroneously applied its own personal standards, instead of those provided by SRCR 3(4), to determine whether to seal a record.

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Nothing in SRCR 3(4) suggests that a party's interest in confidentiality evaporates merely because an opponent publishes confidential information to the jury. Yet the district court denied United's request to seal the following pages based on its misunderstanding that in general, information published to the jury cannot be sealed: P066.002; P089.0058; P236.0002; P236.0011; P266.0002; P266.0004; P266.0005; P266.0008; P266.0011; P266.0032; P268.0001; P268.0002; P273.0002; P288.0070; P288.0176; P294.0001; P294.003; P329.0044; P361.0002; P403.0002; P421.0001; P423.0002;



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P426.0012; P447.0003; P447.0006; P450.0001; P455.0001; P455.0003; P462.0023; P462.0026; P471.0003; P476.0002; P509.003; Trial Exhibit Number 1001, page 1001_005. (15 App. 3684, 3693, 3712, 3717, 3718, 3719, 3720, 3729, 3732, 3733, 3734, 3737, 3742, 3747, 3748, 3749, 3754, 3755, 3756, 3757, 3758, 3773, 3775, 3776.)

The district court first demonstrated its misunderstanding of the applicable standards to seal trial records when it repeatedly declared that it would not seal any exhibit admitted at trial. (1 App. 236:5-6, 237:17-18, 240:2-4.] Although the district court ultimately was inconsistent in applying that rule, the court's analysis and order remained infected by that threshold misunderstanding.[5] In particular, the district court's final determinations applied the categorical rule that

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[5] Indeed, TeamHealth's opening argument in its opposition to United's motion to seal was to remind the district court that it had already determined that it would not seal any document that was admitted at trial:

> This motion is only about ***admitted*** trial exhibits. The Court's position on such documents has already been made clear: "I can tell you right now that I will not seal anything that's admitted. It's not going to happen[]"; "I can tell you I won't seal any exhibit that gets admitted. I think I made that clear[]"; "[I]f . . . it gets admitted it's in the public domain." 1 App. 236:5–6; 237:17–18; 240:2–4.

(12 App. 2986:1-5.)



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any page that included information shown to or discussed with the jury cannot be sealed. *See, e.g.*, 32 App. 7635:19-21 ("[I]t came up at trial, and you don't want it now to be a matter of public record. That's troublesome for me."); 32 App. 7651:1-2 ("denied for the reason that the jury saw this page"). The district court also denied redactions on the similarly categorical basis that information related to the merits of the case could not be sealed. *See, e.g.*, 32 App. 7769:2 (denying redaction to P273.13 because the information "goes to the heart of the case"); 32 App. 7662:22-23 ("all of this information came out during the trial"); 32 App. 7665:1-2 ("all of this came up at the time of trial"). But as noted above, if information relevant to trial were categorically exempt from sealing, the Rules Governing Sealing and Redacting Court Records would serve no purpose.

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The Rules Governing Sealing and Redacting Court Records apply to civil actions and make no distinction between pre-trial, trial, or post-trial court records. *See* SRCR 1(4) (identifying the "Scope" of the rules to "apply to all court records in civil actions"); SRCR 2(2) (defining "Court record" to include "[a]ny document, information, exhibit, or other thing that is maintained by a court in connection with a judicial



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proceeding"). Exhibits admitted at trial, and even testimony elicited at trial, are like any other court record and may be sealed under the SRCR. *See, e.g.*, *In re Elec. Arts, Inc.*, 298 F. App'x 568, 569-70 (9th Cir. 2008) (issuing mandamus when the district court ordered that a trial exhibit containing trade secrets would not be sealed if admitted into evidence); *Bhagat v. Diamond Info. Sys., LLC*, 84 Va. Cir. 233, 2012 WL 7827846 (Va. Cir. 2012) (sealing trial exhibits to maintain a protective order). It was error for the district court to apply a categorical rule without considering whether a significant interest enumerated in SRCR 3(4) applied. That is, the district court applied the erroneous legal principle that, despite the fact that SRCR 3(4) provides various instances of when the public interest in privacy outweighs the public interest in open court records, no privacy interest could be greater than the public interest in access to trial testimony and exhibits.

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The district court's erroneous legal interpretation was particularly harmful and circular under these circumstances. The district court urged United to resolve its sealing issues with TeamHealth so that United would not seek to seal the courtroom every time confidential information was presented at trial. (1 App. 238–40.) The resolution



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urged by TeamHealth, and agreed to by United, was for United to move to seal the documents following trial. *See, e.g.*, 1 App. 112 (Opposition to Objection to Media Request) (TeamHealth offering "a reasonable alternative" to allow United to move post-trial to seal documentary evidence rather than objecting and moving to seal the courtroom each time evidence came up). As a result, United did not move to close the courtroom whenever a confidential document was raised. But after trial, the district court completely eviscerated that resolution by ruling that any information presented at trial was public record and could not be sealed. So, in addition to being the improper legal standard, the district court's personal standard was extremely prejudicial to United in light of the agreed upon method for handling confidential documents at trial. Had United known that the district court would persist in its incorrect standard, United would have insisted on interrupting trial and objecting to information in exhibits as confidential and sealing the courtroom during those portions of the trial.

In sum, despite the protective order contemplating that exhibits shown to the jury and admitted at trial could remain confidential, and despite the agreement of the parties about how to handle potentially



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sealable evidence at trial, the district court categorically ruled that pages shown to the jury or that related to topics discussed at trial could not be sealed. Because the district court was required to weigh the public interest against United's interest in having the exhibits sealed, the district court clearly erred by applying a categorical rule that any page that was published to the jury or discussed in opening statements or closing arguments cannot be sealed.

### C. The District Court Erred by Refusing to Seal or Redact United's Trade Secrets Based on Misunderstandings of Trade Secret Law

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The district court committed further clear legal error by failing to apply the correct legal standards in determining whether the information was entitled to protection from disclosure as trade secrets.

The Sealing and Redacting Court Records Rules require sealing records as needed to protect trade secrets. In other words, under SRCR 3(4)(g), if information is a trade secret, then it must be sealed even if it is part of a court record.

This rule is consistent with Nevada's statutory protections for trade secrets, and the manner in which courts protect trade secrets all across the country. *See, e.g.*, NRS 600A *et seq*. (Nevada Uniform Trade



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Secrets Act); *see also, e.g.*, *Saini v. Int'l Game Tech.*, 434 F. Supp. 2d 913, 921 (D. Nev. 2006) ("[W]e find that the public's interest in uncovering any sale of defective gambling devices is not so great as to outweigh the public interest in enforcement of trade secret and confidentiality agreements."); *Uncle B's Bakery, Inc. v. O'Rourke*, 920 F. Supp. 1405, 1438 (N.D. Iowa 1996) ("[T]he court finds that the public interest in protection of trade secrets weighs in favor of an injunction to accomplish that end."); *JetSmarter Inc. v. Benson*, 2018 WL 2709864, at *8 (S.D. Fla. Apr. 6, 2018) ("Florida law, however, makes plain that protecting trade secrets does not disserve, but rather promotes the public interest."); *Zenith Radio Corp. v. Matsushita Elec. Indus. Co.*, 529 F. Supp. 866, 905 (E.D. Pa. 1981) ("[T]here can be no doubt that society in general is interested in the protection of trade secrets and other valuable commercial information.").

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It also makes sense as a policy matter: when it comes to trade secrets, the people through their elected representatives have already decided that this information should remain confidential. No judicial second-guessing is necessary or appropriate.

In this case, United disclosed documents under a protective order



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that contain trade secrets that can only remain protected if sealed. *See Valley Broad. Co.,* 798 F.2d at 1294 (noting that the publication of trade secret materials "counsels against" providing public access to the judicial process). Thus, the only evidence before the Court—declarations from United—which established that the information in the exhibits included protected trade secrets.

Instead of applying NRS chapter 600A and SRCR 3(4)(g), however, the district court created exceptions to trade-secret protection based on incorrect legal standards, accepting TeamHealth's argument that compilations of public data or otherwise old information cannot be trade secrets. *See Matter of Tiffee*, 137 Nev. at 225, 485 P.3d at 1251 ("A district court abuses its record sealing discretion when it commits legal error.").

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### *1. United Demonstrated that the Exhibits Were Trade Secrets and TeamHealth Failed to Rebut that Showing*

NRS 600A.030(5) defines a trade secret as

> information . . . that derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other persons who can obtain commercial or economic value from its disclosure or use; and . . . is the subject of efforts that



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are reasonable under the circumstances to maintain its secrecy.

a. UNITED ESTABLISHED THAT THE EXHIBITS SUBJECT TO ITS MOTION ARE TRADE SECRETS THAT SHOULD BE SEALED

United's strategic business plans and other portions of the highly confidential trial exhibits are valuable precisely because of their confidentiality. That is, the information derives economic value from not being generally known to and/or readily ascertainable by United's competitors, clients, and medical providers.

The district court misunderstood the nature of United's business and assumed insurers know everything about each other and have the same business model. *See* 31 App. 7493:21–7494:1]. That assumption is decidedly wrong. The market for commercial fully insured and self-funded customers is highly competitive. (*See* 17 App. 3952 at ¶8.)[6] The

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[6] S*ee also* Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 Am. J.L. 7 Med. 243, 262 (2012) ("There is cut-throat competition among large and sophisticated suppliers who deal with sophisticated employers who know that if they do not supply decent coverage to their employees, they risk the loss of their services. There are smaller group purchasers that are anxious about healthcare costs, and individuals who also search the market.").



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Strategic Business Plans produced by United contain highly sensitive competitive and commercial proprietary and non-public information, including business strategy; information about third party pricing and/or reimbursement rates; internal financial data not publicly disclosed to investors or included in its filings with the SEC such as United's profit targets from 2021 to 2026 and how they intend to achieve those targets; business results and projections; United's goals and strategies for entering new markets; and future product designs that, if disclosed, would significantly harm business advantages of United and which deserve the utmost protection from United's competitors and public disclosure.[7] (*Id.*)

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***(i) The Information Derives Economic Value from Not Being Generally Known***

As was detailed for the district court in the Declarations of Dan Keuter, (17 App. 3952–53 at ¶¶ 8-11), and Jenny Hayhurst, (17 App. 3959–60 at ¶¶ 7-11), disclosure of this information will give United's

[7] Arguably, it is not in the public interest to release unreported financial information outside of the regulatory framework of the U.S. Securities Exchange Commission precisely because selective disclosures of financial information can negatively impact fair trading in financial markets. *See, e.g.*, SEC Regulation FD, 17 CFR 243.100-243.103.



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competitors and clients a significant advantage since they would have a roadmap for how to out-compete United in a variety of arenas. Broadly, the Strategic Business Plans and portions of the other Highly Confidential Exhibits this petition seeks to seal provide competitors information on (1) what United sells (i.e. detailed product information); (2) how United prices what it sells (i.e. margin information, pricing strategies, risk adjustment, etc.); (3) who United sells to (i.e. by customer size or funding type); (4) where United sells its products and services (i.e. United's existing footprint and geographic priorities); and (5) how United seeks to out-compete its competitors (i.e. affordability initiatives, network strategies, etc.). (17 App. 3952 ¶ 9.) Information such as United's business objectives, strategies for achieving their financial goals, and the considered strength and weaknesses of United and their peers is not known to United's competitors, clients, or investment analysts and, indeed, is not even widely shared within United's organization. *Id.*

The strategic business plans United sought to redact are highly sensitive internal documents that are not part of the securities filings required by the SEC and whose distribution is strictly limited even



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within United's organization. (17 App. 3952–53 at ¶ 10.) Despite the extraordinary sensitivity of these documents, United, with a few exceptions, proposed to only redact and/or seal the portions of the at-issue trial exhibits that were not shown to the jury on the courtroom monitor or discussed with a witness at trial.

Two examples of the most sensitive documents are a 2020 business plan and internal presentation detailing United's strategic goals for a core business division. *See* P447; P273 (29 App. 6998; 25 App. 6002). The 2020 business plan sets forth, among other things, (1) specific actions United's competitors in that space have taken and what actions United will take in response to those actions (P447.0003); (2) United's financial plan (P447.0004, P447.0021-25); (3) United's strategic priorities and steps to achieve those priorities (P447.0005); and (4) United's 3-5 year growth plan (P447.0017). Similarly, the 2020 internal strategy presentation includes United's internal future profit targets (P273.0003) and a study on how United's this business division can meet its strategic goals (P273.0006-29). (29 App. 7000, 7002, 7018–20, 7002, 6934; 28 App. 6004; 26 App. 6187, 6195–97; 25 App. 6007–30.)

Over ninety-eight percent of the material in the above example

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documents was not even referenced by TeamHealth Plaintiffs' counsel or a witness in the trial record and thus has no relevance to the issues in dispute. From P273, a highly sensitive 198-page document concerning United's goals and business strategies (25 App. 6002), plaintiffs only discussed three pages at trial. From P447, a 27-page business plan (29 App. 6997), plaintiffs only discussed page six with the jury.

Yet, without intervention from this Court the TeamHealth plaintiffs intend to post all 225 pages of these exhibits online. Although the district court partially sealed parts of these documents by allowing redaction of very limited financial figures, the district court failed to seal the overwhelming majority of the sensitive information in those documents. These documents, and other trial exhibits like them, give United's competitors an unfair roadmap for competing against United. They also give investment analysts valuable internal data that will lead to market volatility and manipulation if publicly released. As evidenced by the financial impacts TeamHealth caused Multiplan when TeamHealth previously disclosed United's confidential business plans on the TeamHealth website, these concerns are not just theoretical.

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The irreparable business harm that United will suffer from public disclosure of the strategic business plans and portions of the other highly confidential exhibits easily outweighs any public interest in reviewing that information.

***(ii) United Takes Reasonable Steps in the Course of Business to Protect its Strategic Plans and Confidential Information***

United takes reasonable steps in the ordinary course of business to protect the strategic business plans and other documents of the like, as required for a trade secret. *See* NRS 600A.030(5). As detailed in the declaration of Dan Kueter, "[i]n the ordinary course of business, [United] use[s] several methods to protect their highly competitive and commercially sensitive proprietary and non-public information like the Strategic Business Plans and other [highly confidential exhibits]." (17 App. 3951, at ¶ 5.) At the highest level, United maintains a non-disclosure and confidentiality policy that sets forth how and when highly competitive and commercially sensitive proprietary and non-public information can be used and disclosed. *Id.* Each new hire must agree to abide by this policy as a condition of employment, and to participate in a privacy and security training program. *Id*. Thereafter, each employee of United is required to participate in an annual privacy

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and security training program. *Id.* Each new hire must also participate in an intellectual property protection training program. *Id.* United also protects its highly competitive and commercially sensitive proprietary and non-public information through other information security policies that were designed to protect and limit access to such information. *Id.*

In short, the Strategic Business Plans and the Highly Confidential Exhibits are documents that are "the subject of efforts that are reasonable under the circumstances to maintain [their] secrecy" under NRS 600A.030(5). Because these exhibits contain proprietary information and trade secrets, as defined in NRS 600A.030(5), sealing that information is appropriate. United met its burden to show compelling reasons to seal this trade secret information, and the district court abused its discretion by failing to do so.

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b. TEAMHEALTH FAILED TO REBUT UNITED'S SHOWING

The district court effectively ignored the sworn declarations from United that the information was highly confidential and damaging to United's competitive interests in favor of TeamHealth's counsel's speculations that various information was either publicly available or stale because it was old. *See* 32 App. 7686–87 (United arguing that "if



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you're balancing the persuasiveness, an executive at the company and the sworn affidavit versus speculation by a lawyer that it's stale and won't help, you ought to come down on the side of the affidavit"). Indeed, United recognized that the district court was discounting its declarations, despite no actual evidence from TeamHealth, and requested an evidentiary hearing. *See, e.g.*, 32 App. 7580–81 (United's counsel asking for evidentiary hearing because TeamHealth "challenged our factual evidence, but they haven't done so through declarations or witnesses or experts" yet the court "essentially disregarded or discounted the factual evidence" in the declarations).

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United specifically explained to the district court that staleness was an issue that could best be addressed in an evidentiary hearing and that the court and TeamHealth's counsel could test their theories of staleness through cross examination of United's witnesses. *See* 32 App. 7582–83. Nonetheless, the district court refused to consider witness testimony, finding that the briefing was sufficient. *See* 32 App. 7585:13-16 ("I just don't see why it would be necessary to have evidence on these issues. I think the matters are so fully briefed and so well argued that it's just not necessary."). The district court manifestly



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abused its discretion by refusing an evidentiary hearing and not applying any evidentiary burden to TeamHealth to rebut United's evidence.

In sum, United presented two declarations in support of its arguments that the trial exhibits subject to the motion to seal must remain confidential. In response, TeamHealth's counsel simply argued without evidence that the documents were old, stale, made of publicly available information, or widely known in the industry. Rather than hold an evidentiary hearing, as United requested, the district court largely agreed with Team Health's counsel's arguments. Given that United presented evidence that the trial exhibits contained trade secret information that must be redacted to protect United, the district court manifestly abused its discretion by simply accepting opposing counsel's argument that they were not.

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As discussed immediately below, the district court created judicial exceptions to trade-secret protection that defy trade-secret law and this Court's sealing rules.

### *2. Trade Secrets Can be Developed from Publicly Available Information*

The district court demonstrably misunderstood what a trade



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secret is, particularly with respect to compilations of public information. According to the district court, compilation of otherwise publicly available information cannot be a trade secret. *See* 32 App. 7762 (district court: "I just don't see where information that a consultant obtained from public data could be a trade secret. So it will be denied."); 32 App. 7767 (district court: "I'll deny the request for redaction, because it is – really a compilation of data.").

This Court recently came to the exact opposite conclusion. *See Nevada Indep. v. Whitley*, 138 Nev., Adv. Op. 15, 506 P.3d 1037, 1045 (2022). One of the issues in *Whitley* was whether an insulin manufacturer was entitled to trade secret protections for insulin pricing schemes, even though it its pricing was publicly available information. The Court favorably cited to *Mallet & Co. Inc. v. Lacayon*, 16 F.4th 364, 386 (3d Cir. 2021), for the proposition that "information will not necessarily be deprived of protection as a trade secret because parts of it are publicly available." *Whitley*, 506 P.3d at 1045.

*Whitley* & *Mallet* do not stand alone. To the contrary, "[c]ourts have long recognized that 'a trade secret can exist in a combination of characteristics and components, each of which, by itself, is in the public



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domain, but the unified process, design and operation of which, in unique combination, affords a competitive advantage and is a protectable secret." *AirFacts, Inc. v. de Amezaga*, 909 F.3d 84, 96 (4th Cir. 2018); *see*, *e.g.*, *3M v. Pribyl*, 259 F.3d 587, 595-96 (7th Cir. 2001) (same); *Imperial Chemical Industries Ltd. v. National Distillers & Chemical Corp.*, 342 F.2d 737, 742 (2d. Cir. 1965) (collecting cases in support of same); *Enter. Leasing Co. of Phoenix v. Ehmke*, 3 P.3d 1064, 1069 (Ariz. Ct. App. 1999) ("[A] trade secret may consist of a combination of elements even though each individual component may be a matter of common knowledge."); *State ex rel. Lucas Cty. Bd. of Commrs. v. Ohio Environmental Protection Agency*, 724 N.E.2d 411, 419 (Ohio 2000) ("Where documents already in the public domain are combined to form a larger document, a trade secret may exist if the unified result would afford a party a competitive advantage.") (quoting *The Plain Dealer v. Ohio Dept. of Ins.*, 687 N.E.2d 661, 674-75 (Ohio 1997)).

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Indeed, the statutory definition of "trade secret" itself includes a "compilation" of information. *See* NRS 600A.030(5)(a) ("'Trade Secret' . . . Means information, including, without limitation, a formula,



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pattern, *compilation*, program, device, method, technique, product, system, process, design, prototype, procedure . . . .") (emphasis added).

That settled rule applies here. Many of the documents the district court refused to seal reflect otherwise public information that United compiled and combined in a way to create a competitive advantage. For example, P273 included compilations from McKinsey & Company that were disclosed as attorneys' eyes only by United. Page twelve of P273 reveals the relative importance of various products and programs to United's earnings. (25 App. 6013.)

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This page is one example of many in P273 in which United's working relationship with a consulting company and its analysis would give insight and information into how United thinks about its growth opportunities and which specific growth opportunities it is considering. That information is treated as highly confidential and sensitive within United, and is the reason United designated it "Attorneys' Eyes Only." But because the information was compiled from publicly available sources, TeamHealth argued that it was not confidential and "just a graph of public data." (32 App. 7766:7-16.) The district court agreed on the basis that it "really is a compilation of data." (32 App. 7767:6.)

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The district court erred by refusing to grant further sealing redactions to P273 based on its misunderstanding that compilations of public data were not trade secrets. As a result, this Court should order the district court to apply the correct legal standard regarding compilations of data when determining whether to seal United's trade secrets. Given the paucity of the district court's analysis, it is impossible to determine the full extent to which this flawed legal interpretation infected the district court's sealing determinations. The district court should be instructed on the correct legal rule and directed to reconsider all of United's motion to seal in light of the correct rules of law.

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### *3. Staleness is a Case-Specific Inquiry Not Dependent on the Age of the Information*

TeamHealth also opposed United's motion to seal, in part, on the theory that the records "cannot possibly have any value as trade secret or proprietary because the information is stale." (12 App. 2989.) TeamHealth argued that "the majority of these documents were well over two years old—many of them over five or even as many as fifteen years out of date." (12 App. 2990.) TeamHealth relied on the age of the documents to argue that they were presumptively stale. *See, e.g.* 12 App. 2990 n.3 ("In some cases, even a matter of months can render



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information stale.”). The district court credited TeamHealth’s arguments and improperly required disclosure of confidential and trade secret documents based solely on when they were prepared, without any inquiry into the *continued* need for confidentiality. *See* 32 App. 7738 (court finding that “[i]t’s just stale information, and it deals with other public entities.”); 32 App. 7740–41 (TeamHealth arguing that 2017 is not “still relevant to the marketplace today” and court denying motion to seal).

Staleness is a fact-specific inquiry that cannot be triggered by singular, rigid factors such as the age of a document. *See Synergetics, Inc. v. Hurst*, 477 F.3d 949, 958 (8th Cir. 2007) (“Determinations of when trade secret information becomes stale cannot be made by reference to a bright line rule and necessarily requires fact specific consideration.”). Information does not lose status as a trade secret solely as a function of time; rather, information no longer constitutes a trade secret when the information loses its commercial value to competitors. *Cf. Enter. Leasing Co. of Phoenix v. Ehmke*, 3 P.3d 1064, 1069 (Ariz. Ct. App. 1999) (recognizing that “trade-secret status may continue indefinitely so long as there is no public disclosure”).

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TeamHealth argued that United was required to show that older plans were still the current plans, otherwise the information was stale and not a trade secret. *See, e.g.*, 31 App. 7443:1-3 (arguing that "none of the declarations, none of the evidence from United, supports a finding that these old business plans are still current strategies"). Even if information "does not provide direct insight into current business strategies," however, it is still relevant and can be a trade secret if "the information can be extrapolated to predict future strategies and practices." *Stanislaus Food Products Co. v. USS-POSCO Industries*, 2012 WL 6160468, *2 (E.D. Cal. 2012). That principle applies to many of the documents at issue, but the district court simply refused to apply it.

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For example, P329 is a strategic business plan from 2019. TeamHealth argued the information was stale because, although created for 2019, it was never intended for release to the general public and United's competitors. Page 15 of this document, along with numerous others, details United's business strategies for growth and improving their cost structures. (27 App. 6492.) Those strategies were not specific to 2019 and did not "expire" that year—they remain



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relevant today. It thus does not matter that 2019 has "already come and gone," as TeamHealth argued. (12 App. 2992:9.) Because information from the 2019 document can be extrapolated to identify United's future strategies and practices, it remains a trade secret and United's confidential information. *See Stanislaus Food Products Co.*, 2012 WL 6160468, at *2. TeamHealth presented no evidence to the contrary. It was error to order such information to be unsealed.

Similarly, P378 is a 2019 analysis of United's market competitiveness in Employer & Individual plans. Although prepared in 2019, it includes analyses of current and future network competitiveness (28 App. 6719–21, 6725), ways to improve performance (28 App. 6727, 6731–33), percentages of reduction off billed amounts (28 App. 6734), an analysis of United's distribution of spend by program (28 App. 6735), and a five-year roadmap with financial targets through 2023 (28 App. 6736). All of this information was designated attorneys' eyes only and is highly sensitive to United and gives United's competitors insight into how United assesses its competitiveness and future growth opportunities.[8]

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[8] TeamHealth sought to unseal numerous documents based on its



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United asks this Court to direct the district court to seal those documents that were confidential under the protective order, or alternatively to direct the district court to reconsider United's sealing requests in light of the correct legal analysis for staleness.

### D. Sealing is Justified Based on the Compelling Circumstances of this Case

Finally, a court may seal documents when "[t]he sealing or redaction is justified or required by another identified compelling circumstance." SRCR 3(4)(h). "In general, 'compelling reasons' sufficient to outweigh the public's interest in disclosure and justify sealing court records exist when such 'court files might have become a vehicle for improper purposes,' such as the use of records to gratify private spite,

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incorrect understanding of staleness, including: PX1; PX3; PX5; PX8; PX10; PX16; PX22; PX23; PX25; PX26; PX34; PX53; PX66; DX4569; DX5507; PX67; PX71; PX73; PX75; PX76; PX92; PX94; PX96; PX127; PX132; PX509; DX5499; PX144; PX147; PX148; PX149; PX150; PX154; PX159; PX170A; PX174; PX175; PX178; PX193; PX212; PX218; PX220; PX229; PX230; PX231; PX236; PX239; PX243; PX244; PX246; PX254; PX256; PX265; PX266; DX5506; PX262; PX267; PX268; PX270; PX273; PX288; PX294; PX297A; PX297S; PX314; PX319; PX320; PX324; PX329; PX340; PX342; PX344; PX348; PX354; PX359; PX360; PX361; PX367; PX368; PX370; PX375; PX378; PX380; PX394; PX395; PX400; PX403; PX413; PX418;1 PX421; PX423; PX426; PX440; PX444; PX447; PX462; PX476; PX477; PX471; PX483; DX4048; DX4478; DX4573; DX5505; PX450; PX455; PX464; PX472. *See* 13 App. 2992:10-21, 3002.



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promote public scandal, circulate libelous statements, or release trade secrets." *Kamakana v. City & Cty. of Honolulu*, 447 F.3d 1172, 1179 (9th Cir. 2006); *see also Valley Broad. Co.*, 798 F.2d at 1294 (orders to seal are appropriate when there is a "likelihood of an improper use," including the publication of "trade secret materials" and the infringement of "residual privacy rights"). TeamHealth's conduct in disclosing the Strategic Business Plans midtrial, and the harm that then resulted from their actions, constitute independent compelling circumstances that warrant the sealing and redactions. *See* 76 C.J.S. Records § 82 ("[C]ompelling reasons sufficient to outweigh the public's interest in disclosure exist when court records might become a vehicle for improper purposes, such as the use of records to gratify private spite, promote public scandal, circulate libelous statements, or release trade secrets.").

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TeamHealth has not been shy about how it will use the trial exhibits to "gratify private spite," "promote public scandal," and "release trade secrets." Not only did it already once disclose confidential documents, but it is openly broadcasting that it intends to do so to the full extent this Court will allow it. The vast majority of the information



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TeamHealth threatens to publish has no relevance to this case, was not displayed in the courtroom, and was not addressed by witnesses or counsel at trial. The information instead involves internal business strategies about products, partnerships, marketing, financial targets and similar information. Disclosing such information serves no purpose related to open court records, or any public purpose at all. It serves only to advance the TeamHealth Plaintiffs' strategy to impact other pending cases by exerting pressure on United unrelated to the merits of the reimbursement rate issues in this case. This is a textbook example of a litigant using "court files… [as] a vehicle for improper purposes." *Kamakana*, 447 F.3d at 1179.

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Beyond the act itself of using sealed documents to "gratify private spite," "promote public scandal," and "release trade secrets," the results of that conduct further support the need to seal the Strategic Business Plans and redact portions of the other Highly Confidential Exhibits. *See Hunt v. Zuffa, LLC*, 528 F. Supp. 3d 1180, 1188 (D. Nev. 2021) (finding "compelling reasons" to seal when "exhibit contain[ed] confidential business information, public disclosure of which could potentially damage the parties' competitive standing"). A court will not ordinarily



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have the benefit of hindsight in determining the extent of harm that would result from disclosure of confidential documents. But the district court did.

When TeamHealth posted United's confidential information to its website, the damage was immediate. A nonparty's stock value and bond rating fell when investors learned from United's AEO documents that United had considered terminating certain contracts with that nonparty in 2023. *See* 17 App. 3931–47. After TeamHealth's previous leak affected Multiplan, it should have been apparent that these documents are highly sensitive and that their disclosure is disruptive to United and the market. The harm that will result from disclosure was demonstrated to the district court in real time. Yet the district court chose to allow disclosure of the Strategic Business Plans and unredacted copies of the other Highly Confidential Exhibits, which can only be expected to cause even greater damage than what happened the first time.

This recent real-world experience alone established the particularized showing the district court needed to justify sealing judicial records. The district court thus erred by failing to do so here.



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## CONCLUSION

The district court and plaintiffs must be enjoined from publishing to the world United's highly sensitive, confidential documents, which would cause irreparable damage both to United and those third parties who work with United and depend on this confidentiality.

For these reasons, this Court should grant the petition.

Dated this 15th day of November, 2022.

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## CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the formatting, typeface, and type-style requirements of NRAP 32(a)(4)–(6) because it was prepared in Microsoft Word 2010 with a proportionally spaced typeface in 14-point, double-spaced Century Schoolbook font.

2. I certify that this brief exceeds the type-volume limitations of NRAP 21(d) because, except as exempted by NRAP 32(a)(7)(C), it contains 12,657 words.

3. I certify that I have read this brief, that it is not frivolous or interposed for any improper purpose, and that it complies with all applicable rules of appellate procedure, including NRAP 28(e). I understand that if it does not, I may be subject to sanctions.

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Dated this 15th day of November, 2022.

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## CERTIFICATE OF SERVICE

I certify that on this 15th day of November, 2022., I served the foregoing "Petition for Writ of Mandamus or, Alternatively, Prohibition" for filing *via* the Court's eFlex electronic filing system. Electronic notification will be sent to the following:

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I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

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# 2018 Associate Benefits Book

## Summary Plan Description

## What's inside

Medical plan
Pharmacy benefit
Dental plan
Vision plan
Life insurance and disability
Walmart 401(k) Plan
Resources for Living®
...and much more!

Effective **January 1, 2018**

# Table of Contents


| | |
|---|---|
| Eligibility and enrollment | 4 |
| Eligibility and benefits for associates in Hawaii | 36 |
| The medical plan | 42 |
| The pharmacy benefit | 84 |
| Health Savings Account | 92 |
| The dental plan | 100 |
| The vision plan | 108 |
| COBRA | 114 |
| Resources for Living® | 122 |
| Critical illness insurance | 126 |
| Accident insurance | 132 |
| Company-paid life insurance | 138 |
| Optional associate life insurance | 144 |
| Optional dependent life insurance | 150 |
| Accidental death and dismemberment (AD&D) insurance | 156 |
| Business travel accident insurance | 162 |
| Short-term disability for hourly associates | 168 |
| Salaried short-term disability plan | 176 |
| Truck driver short-term disability plan | 184 |
| Long-term disability | 192 |
| Truck driver long-term disability | 200 |
| The Associate Stock Purchase Plan (ASPP) | 208 |
| The Walmart 401(k) Plan | 222 |
| Claims and appeals | 244 |
| Legal information | 262 |
| Glossary of terms | 276 |
| For more information | 286 |


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

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O puede llamar para cualquier pregunta al 800-421-1362. Tenemos asociados quienes hablan Español y pueden ayudarles a Ud comprender sus beneficios de Walmart. El Libro de beneficios para asociados esta disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.



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# Welcome to your 2018 Associate Benefits Book

This is where you'll find Summary Plan Descriptions (SPDs) for the Associates' Health and Welfare Plan (aka the Plan) and the Walmart 401(k) Plan. It's a great resource to help you understand your benefits, so take a little bit of time and get to know them.

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## Lots of information. So easy to find.

When you download the 2018 *Associate Benefits Book* PDF from the **WIRE** or **WalmartOne.com**, getting answers to your benefits questions is easy and fast.

To find what you need, just launch the PDF with Adobe Reader and click "edit" on the top toolbar. Then click "search." From there, just type in what you're looking for. Want to know about coverage for preventive care? Type in "preventive" and click "search." You'll get instant results!

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# Eligibility and enrollment

## WHERE CAN I FIND?


| | |
|---|---|
| The Associates' Health and Welfare Plan | 6 |
| Associate eligibility | 6 |
| Part-time hourly and temporary associates: eligibility checks for medical coverage | 8 |
| Dependent eligibility | 9 |
| Dependents who are not eligible | 10 |
| Legal documentation for dependent coverage | 10 |
| When your dependent becomes ineligible | 10 |
| When you enroll for benefits | 11 |
| When coverage is effective | 12 |
| Effective dates for benefits under the Plan | 12 |
| Enrollment and effective dates by job classification | 13 |
| Paying for your benefits | 19 |
| Tobacco rates | 19 |
| Benefits continuation if you go on a leave of absence | 20 |
| Benefits continuation if you have an approved disability claim | 21 |
| Changing your benefits during the year: status change events | 21 |
| Making changes in your coverage as a result of status change events | 23 |
| If your job classification changes | 24 |
| Coverage effective dates when transferring from one job classification to another | 25 |
| Qualified Medical Child Support Orders (QMCSO) | 35 |
| When your Plan coverage ends | 35 |


If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 269 in the **Legal information** chapter for more details.



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# Eligibility and enrollment

ELIGIBILITY AND ENROLLMENT RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Enroll in Walmart benefits | Go to the WIRE, WalmartOne.com or Workday | Call People Services at 800-421-1362 |
| Notify People Services within 60 days of a status change event, such as a dependent losing eligibility under the Plan | Go to the WIRE, WalmartOne.com or Workday | Call People Services at 800-421-1362 |
| Notify People Services if you have questions about the payroll deductions for your benefits | | Call People Services at 800-421-1362 |
| Reinstate coverage upon your return from a military leave | | Call People Services at 800-421-1362 |
| Pay premiums for benefits while on a leave of absence | | If you have an approved short-term disability claim through Sedgwick, your premiums will be deducted out of your disability benefit check through payroll. Otherwise, send a check or money order payable to the Associates' Health and Welfare Trust to:<br>Walmart People Services<br>P.O. Box 1039<br>Department 3001<br>Lowell, Arkansas 72745<br>Please be sure to include your name, insurance ID number (found on your plan ID card) or your WIN (Walmart ID) number (if you have HMO coverage) and your facility number on your payment to ensure timely posting of your payment.<br>You may also pay by debit or credit card with a Visa, MasterCard or Discover card by calling 800-421-1362 and saying "make a payment." |

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## What you need to know about eligibility and enrollment

- You can enroll for benefits during your initial enrollment period as a newly eligible associate, during annual enrollment and when you have a status change event.
- When your initial enrollment period begins depends on your job classification. Changes to your job classification may affect your initial enrollment period. Eligibility and benefits information specific to associates in Hawaii is explained in the Eligibility and benefits for associates in Hawaii chapter.
- If you enroll in certain benefits (such as life insurance) after your initial enrollment period, your benefits may be affected.
- Medical, dental, vision, critical illness, accident, and accidental death and dismemberment (AD&D) insurance coverage cannot be changed except during annual enrollment, unless you have a status change event.
- If you choose to enroll in short-term disability enhanced plan coverage or long-term disability coverage options, you may drop your coverage at any time, but you will only be able to add this coverage during your initial enrollment period, annual enrollment or with a status change event.
- If you have an approved short-term disability claim, your premiums for medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident coverage may be deducted out of your benefit checks, which will be issued through the Walmart payroll system.

## The Associates' Health and Welfare Plan

The Associates' Health and Welfare Plan (the Plan) is a single, comprehensive employee benefit plan that offers medical, dental, vision, critical illness insurance, accident insurance, AD&D, business travel accident insurance, life insurance, disability and Resources for Living (employee assistance and wellness) coverage to eligible associates and their eligible dependents. The eligibility for these benefits is described in this chapter, and the terms and conditions for these benefits are described in the applicable chapters of this 2018 *Associate Benefits Book*. The Plan is sponsored by Wal-Mart Stores, Inc.

You are automatically enrolled for certain benefits under the Plan on your date of hire or a later date. For other benefits, however, you must enroll for coverage to take effect. Refer to the **Enrollment and effective dates by job classification** section in this chapter for details about initial enrollment periods and when coverage is effective, for all benefits available under the Plan.

## Associate eligibility

The benefits you are eligible for depend on a number of factors, which may include your hire date, average weekly hours and your job classification in the company's (Wal-Mart Stores, Inc.) payroll system. In addition, for most benefits, you may be required to meet the applicable waiting period. See the **Enrollment and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for and for your benefits eligibility waiting period based on your job classification.

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

### MANAGEMENT ASSOCIATE ELIGIBILITY

To be eligible for benefits as a management associate, you must be classified in the company's payroll system as a management associate, management trainee, California pharmacist or full-time truck driver.

### FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a full-time hourly associate, you must be classified in the company's payroll system as a full-time hourly associate.

### MANAGEMENT AND FULL-TIME HOURLY ASSOCIATES: IF YOU HAVE A BREAK IN SERVICE

**If your employment ends and you return to employment within less than 31 days,** you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan).

**If your employment ends and you return to employment after 30 days and before 13 weeks,** you will be automatically re-enrolled in the same coverage you had before you left, but your annual deductibles and out-of-pocket maximum will reset and you will be responsible for meeting the new deductibles and out-of-pocket maximum in their entirety. You will have 60 days to drop or otherwise change the medical, dental, vision, AD&D, critical illness and accident coverage in which you were automatically re-enrolled.

**If your employment ends and you return to employment after 13 or more weeks,** you will be treated as if you were a new associate.

### PART-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a part-time hourly associate, you must be classified in the company's payroll system as a part-time hourly associate.

To be eligible to receive medical benefits, you must work an average of at least 30 hours per week, with the following exceptions:

- Part-time hourly pharmacists hired on or after February 1, 2012, must work an average of at least 24 hours per week.
- Part-time hourly pharmacists hired prior to February 1, 2012, do not need to work a minimum number of hours per week.
- Part-time field Logistics must work an average of at least 24 hours per week.
- Part-time truck drivers do not need to work a minimum number of hours per week.

Part-time associates are subject to the annual eligibility check process described later in this chapter, with the exception of part-time hourly pharmacists hired prior to February 1, 2012, and part-time truck drivers. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you worked on average in the 52-week period preceding the date of the annual eligibility check. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical coverage**.

### TEMPORARY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a temporary associate, you must be classified in the company's payroll system as a temporary hourly associate.



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To be eligible to receive medical benefits, you must work an average of at least 30 hours per week. Temporary pharmacists hired on or after February 1, 2012, and temporary field Logistics must work an average of at least 24 hours per week.

Temporary associates are subject to the annual eligibility check process described later in this chapter. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you worked on average in the 52-week period preceding the date of the annual benefits eligibility check. For more information, see the section titled Part-time hourly and temporary associates: eligibility checks for medical coverage.

### HAWAII ASSOCIATES

Special rules govern eligibility and enrollment in the state of Hawaii. If you are a full-time hourly, part-time hourly or temporary associate in Hawaii, please refer to the Eligibility and benefits for associates in Hawaii chapter of this Summary Plan Description for information regarding eligibility for benefits. For management associates in Hawaii, the eligibility and enrollment terms described in this Eligibility and enrollment chapter apply.

### HOURLY ASSOCIATES WITH SALARIED STATUS

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

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

### INELIGIBLE ASSOCIATES

Ineligible associates (those associates who are not otherwise eligible for other Plan benefits) may still receive Resources for Living and business travel accident insurance benefits.

### ELIGIBILITY RULES FOR CERTAIN INSURED BENEFITS

HMO and eComm PPO Plans are available for some facilities. The policies for the HMO and eComm PPO Plans may have different eligibility requirements and waiting periods than those described in this chapter. If you enroll for coverage under an HMO or a PPO, the enrollment materials and certificate of plan coverage you receive may describe the eligibility terms of the HMO or PPO. Please note that if there is any difference between the HMO's or PPO's eligibility terms and the eligibility terms of the Associates' Medical Plan, as described in this chapter, the Plan will apply its own eligibility requirements.

In addition, where permitted by law, some HMOs require participants to accept an arbitration agreement before benefits under the HMO can become effective. If you enroll in an HMO and do not return the signed arbitration agreement within 60 days of your initial enrollment, your HMO benefits will not take effect.

### LOCALIZED ASSOCIATES

Associates who have been approved by the company as having localized status, and their dependents residing in the United States, will be eligible for the same benefits under the Plan as associates who are United States citizens residing and working in the United States, including medical, dental, vision, life, disability and any other benefit available to United States associates under the Plan. These localized associates and applicable dependents will not be eligible for expatriate coverage under the Plan. For medical benefits where an eligible dependent of a localized associate resides outside the United States, the eligible dependent may choose to use any local provider or a network provider affiliated with the Third Party Administrator through whom the localized associate has coverage, if one is available. Medical benefits will be processed as network claims and paid at the applicable coinsurance rate for network charges, subject to applicable limitations and exclusions under the Plan. The localized associate or their enrolled dependent(s) must file a claim for reimbursement under the Plan's claims procedures. Any applicable waiting period will be waived for localized associates and their covered dependents.

### ASSOCIATES WHO ARE NOT ELIGIBLE

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

- A leased employee
- A nonresident alien (except for optional associate life insurance, optional dependent life insurance, accidental death and disability insurance and business travel accident insurance, and unless covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company)
- An independent contractor
- A consultant
- Residing outside the United States
- Not classified as an associate of Wal-Mart Stores, Inc. or its participating subsidiaries, or
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan).

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

# Part-time hourly and temporary associates: eligibility checks for medical coverage

## INITIAL ENROLLMENT ELIGIBILITY CHECK FOR MEDICAL COVERAGE

If you are a part-time hourly or temporary associate, your initial eligibility for medical benefits is determined by a review of your average hours worked per week over the 52 consecutive weeks beginning on your hire date. This review applies to all part-time hourly and temporary associates, with the exception of part-time hourly pharmacists hired before February 1, 2012, and part-time truck drivers.

If you average at least 30 hours a week (24 hours a week for part-time hourly pharmacists hired on or after February 1, 2012, and part-time field Logistics) over the 52-week review period without a break in employment of 13 weeks or greater, you will become eligible for medical benefits. Specifically, your eligibility will begin on the first day of the calendar month that falls not less than one month and not more than two months after the end of the 52-week review period (i.e., on the first day of the second calendar month following the day before your one-year anniversary date). For example, if you are hired on April 16, 2018, the company will average the hours you work beginning April 16, 2018, through April 15, 2019. If you work an average of at least 30 hours a week over the review period, your coverage (if you enroll in a timely manner) would begin June 1, 2019.

Initial medical coverage for associates who work an average of at least 30 hours a week over the 52-week review period will continue through the end of the second calendar year following date of hire. In the example above, your coverage (if you enroll in a timely manner) would continue through the end of 2020.

## ANNUAL ELIGIBILITY CHECK FOR MEDICAL COVERAGE

Generally, part-time hourly associates (including those initially hired as management or full-time hourly who have been employed one year or more and change to part-time hourly status) and temporary associates will be subject to an annual benefits eligibility check to establish their eligibility for medical benefits for the next calendar year. The annual eligibility check will be administered prior to each calendar year's annual enrollment period.

The measurement period for the annual eligibility check will be the 52 weeks preceding an annually designated date in early October prior to each calendar year's annual enrollment period. For example, the annual check prior to the annual enrollment occurring in fall 2017 (for the 2018 calendar year) will review the associate's hours worked from October 5, 2016, through October 4, 2017. If you meet your appropriate average weekly hours requirement (24 or 30 hours, depending on job classification) over the 52-week period, you will be eligible to enroll in medical benefits during the annual enrollment period for coverage during 2018, in addition to the other benefits to which part-time hourly and temporary associates are eligible

If you do not meet the applicable average weekly hours requirement in the annual eligibility check, your medical coverage may continue for a certain period of time, as described below under **If you do not meet the annual eligibility check for medical benefits.**

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

## IF YOU MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are a part-time or temporary associate who is currently eligible for medical benefits and subject to the annual eligibility check requirement, and you meet the annual eligibility check in October, you will remain eligible for medical coverage for the remainder of the current year. You will receive annual enrollment materials and be eligible to enroll for medical benefits for the following year.

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

## IF YOU DO NOT MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are a part-time hourly or temporary associate who is currently eligible for medical benefits and subject to the annual eligibility check requirement, but you do not meet the annual eligibility check in October, you will:

- Remain eligible for medical coverage for the remainder of the current year (if you are in your initial coverage period, you will be considered eligible for medical coverage through the end of the second calendar year following your date of hire)
- Not be eligible for medical coverage under Walmart's plans for the following year unless your job classification changes and you meet the eligibility requirements based on your new classification, and
- Receive a letter that will explain your options under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical coverage when the calendar year ends.

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

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**IF YOU TAKE TIME OFF OR HAVE A BREAK IN SERVICE**

**Unpaid time off:** If you take any type of unpaid time off that is not an approved leave of absence, as described below, your number of actual service hours will still be used in your average hours calculation (even if it is zero).

**Leave of absence:** If your absence is an approved leave (including for jury duty), Family and Medical Leave Act of 1993 (FMLA) leave or military leave, the average-hours-worked calculation will be based on the number of weeks during the 52-week measurement period that you are working. For example, if you take a leave during two weeks of the 52-week measurement period, your average hours will be calculated over the 50 weeks for which you have actual service hours, rather than 52.

**Break in service**

**If your employment ends and you return to employment within 13 weeks or less:** If you terminate employment during a measurement period but are rehired as a part-time hourly associate within 13 weeks after leaving, for the remainder of the measurement period you will be treated as if you had not left. Your hours will continue to be tracked and used in the average hours calculation. The period you were not employed will be excluded from the 52-week measurement period.

If you terminate employment after the completion of a measurement period and are rehired as a part-time associate within 13 weeks, you retain your previous status through the end of the calendar year, except as noted below. For example, if you are eligible for medical benefits and you enroll before you leave, and you return to the company within 13 weeks, you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan). The impact on your benefits depends on the duration of your break, as follows:

- **If your employment ends and you return within 30 days:** you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan).
- **If your employment ends and you return after 30 days but before 13 weeks:** you will be automatically enrolled in the same coverage you had before you left, but your annual deductibles and out-of-pocket maximum will reset and you will be responsible for meeting the new deductibles and out-of-pocket maximum in their entirety. You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically re-enrolled.

**If your employment ends and you return after 13 or more weeks:** you will be treated as if you were a new associate. You will be required to complete the initial eligibility check before you may be eligible for benefits.

## Dependent eligibility

Dependents who are eligible to enroll in coverage under the Plan ("eligible dependents") are limited to:

- Your spouse, as long as you are not legally separated
- Your domestic partner (or "partner"), as long as you and your domestic partner:
  - Are in an 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. Your dependent children are:
  - Your natural children
  - Your adopted children or children placed with you for adoption
  - Your stepchildren
  - Your foster children
  - The children of your partner, provided your relationship qualifies under the definition of spouse/partner, or
  - Someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support.

**NOTE:** Eligible part-time hourly associates, temporary associates and part-time truck drivers may cover their eligible dependent children, but they may not cover their spouses/partners.

You and your eligible dependents must be enrolled in coverage under the Plan before any benefits will be paid. You have an obligation to promptly drop from coverage any individual who does not satisfy the definition of eligible dependent. If you fail to do so, you may be subject to the loss of benefits and/or loss of employment. You may have only one spouse or partner at a time.

If a court order requires you to provide medical, dental and/or vision coverage for children, the children must meet the Plan's eligibility requirements for dependent coverage. For more information on how the Plan handles a Qualified

Medical Child Support Order (QMCSO), see the **Qualified Medical Child Support Orders (QMCSO)** section later in this chapter.

If you are enrolled in any of the Accountable Care Plan options, the Select Network Plan or an HMO, and you have a dependent living outside the service area of your medical plan, you may still enroll your dependent, but he or she will not have access to network providers in the geographic area and may have access only to emergency coverage. If you are enrolled in any of the Accountable Care Plan options, the Select Network Plan or an HMO and you are unsure if your dependent lives outside your medical plan's service area, call your health care advisor at the number on your plan ID card.

You may change coverage plans for both yourself and your eligible dependent(s) during annual enrollment or if you have a status change event (you and your eligible dependent must be enrolled in the same coverage plan).

**IF YOUR CHILD IS INCAPABLE OF SELF-SUPPORT**

Coverage for your eligible child may be continued beyond the end of the month in which the child reaches age 26 in the following situations:

If the child is covered as an eligible dependent under a Walmart-sponsored medical, dental, vision, critical illness insurance, accident insurance, AD&D or optional dependent life insurance prior to his or her 26th birthday and if both of the following conditions are met:

- The child is physically or mentally incapable of self-support, and
- The child's doctor provides written medical evidence of the child's disability and inability to provide self-support.

In addition, coverage for your dependent child may be added beyond the end of the month in which the child reaches age 26 if both the above conditions are met and the child experiences a valid status change event. Any changes requested as a result of the valid status change event must be consistent with the event and the gain or loss of coverage. For additional information regarding a status change event, refer to the **Changing your benefits during the year: status change events** section of this chapter.

## Dependents who are not eligible

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

- Covered by the Plan as an associate of Walmart (an individual covered under the Plan may be either an associate or a dependent, but not both at the same time), except for optional dependent life insurance, AD&D, critical illness and accident insurance
- Covered by the Plan as a dependent of another associate of Walmart, except for optional dependent life insurance, AD&D, critical illness and accident insurance
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan)
- Residing outside the United States, except those dependents attending college full-time outside of the United States or covered under a specific policy for expatriates or third-country nationals who are employed by the company (this statement does not apply to optional dependent life insurance or dependents of localized associates)
- An illegal immigrant, or
- Not an eligible dependent as defined under **Dependent eligibility** on the previous page.

## Legal documentation for dependent coverage

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

## When your dependent becomes ineligible

You must notify People Services within 60 days from the date your dependent becomes ineligible for coverage under the Plan by calling **800-421-1362**. If you qualify, upon receiving proper and timely notification, the Plan will send an election notice, allowing you to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. To enroll in COBRA coverage, your dependent must elect to receive this coverage within 60 days from the date of his or her election notice. See the **COBRA** chapter for more information.

Failure to notify the Plan when your dependent becomes ineligible for coverage may be considered an intentional misrepresentation of material facts, which may result in coverage being canceled retroactively. In that case, you may be responsible for any charges mistakenly paid by the Plan after the date that your dependent became ineligible. If coverage is canceled, you may be eligible to receive a refund for premiums you paid after coverage was canceled, but only if you notify People Services.



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## When you enroll for benefits

Once you have completed any applicable eligibility waiting period, you can enroll for benefits as follows (for more information, see Enrollment and effective dates by job classification later in this chapter and refer to the chart that applies to your job classification):

- During your initial enrollment period, which is the first time you are eligible to enroll. The timing of your initial enrollment period will vary by job classification and will change if your job classification changes.
- During annual enrollment, which usually occurs in the fall of each year. Benefits you enroll in during annual enrollment are generally effective January 1 of the following year. However, if you enroll in optional associate life insurance or optional dependent life insurance during annual enrollment, coverage for those plans will be effective on the date Prudential approves your coverage, or at the end of your eligibility waiting period, whichever is later. (This date could be before or after January 1 of the following year.)
- When a status change event allows you to make changes to your coverage outside of annual enrollment and is in accordance with federal law.
- If you choose to enroll in the short-term disability enhanced plan or the long-term disability plan during annual enrollment or with a status change 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.
  - 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.

If you are an associate in Hawaii, your eligibility and benefits information is described in the Eligibility and benefits for associates in Hawaii chapter.

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

- Medical, including HMO plans and the eComm PPO Plan
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Short-term disability (STD) enhanced plan
- Long-term disability (LTD), and
- Accidental death and dismemberment (AD&D).

If you are eligible and do not enroll during your initial enrollment period, you may still enroll for optional associate life insurance and optional dependent life insurance during the year by going online through the WIRE, WalmartOne.com or Workday. However, if you do not enroll in these benefits during your initial enrollment period, you will be required to provide Proof of Good Health.

**NOTE:** Guaranteed issue for optional life insurance for associates ($25,000) and optional dependent life insurance for spouses/partners ($5,000) is available only during your initial enrollment period. "Guaranteed issue" refers to the maximum amount of insurance that can be issued without the need to submit Proof of Good Health. Proof of Good Health requires completion of a questionnaire regarding medical history for you and/or your spouse/partner and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll. Proof of Good Health is not required when enrolling in child life insurance under the optional dependent life insurance program.

### CONFIRMING YOUR ENROLLMENT

Once you enroll for coverage, you can view your confirmation statement on the WIRE, WalmartOne.com or Workday. If you believe there is an error regarding which benefits you enrolled in, you should immediately contact People Services at 800-421-1362.

### YOUR PLAN ID CARD

When you enroll in any of the medical plan options available under the Associates' Medical Plan, you will receive a plan ID card at your home address. If your Third Party Administrator (TPA) is BlueAdvantage of Arkansas, Aetna or HealthSCOPE Benefits, plan ID cards for dependents whose address is different from the associate's address will be sent directly to the dependent's address. If your TPA is UnitedHealthcare, plan ID cards for dependents will be sent to you even if their address is different from yours. Your plan ID card will also serve as your pharmacy ID card.

If you enroll for coverage under the Associates' Medical Plan or the eComm PPO Plan (if applicable) and you also enroll in the dental plan and/or the vision plan, your plan ID card will also serve as your Delta Dental ID card and/or your VSP vision plan ID card.

If you enroll in an HMO and you also enroll in the dental plan and/or the vision plan, you will receive separate ID cards for the dental plan and/or the vision plan. If you enroll for the dental plan and/or the vision plan only, you will receive separate ID cards for those plans. ID cards will be mailed to your home address.

You can update your address or that of your dependents who are under the age of 18 when you enroll online or at any time on the WIRE, WalmartOne.com or Workday. If your dependent is age 18 or over, they will need to contact People Services at 800-421-1362 to update their address.

### ATTEMPTS TO ENROLL AFTER HOURS OF OPERATION

If you attempt to enroll for coverage after the normal hours of operation through the WIRE, WalmartOne.com or Workday, or you have tried to make contact with People

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Services on the final day of your initial enrollment period, annual enrollment period or time frame for requesting a change as a result of a family status change, you may enroll on the next business day. However, in no event will you be allowed to enroll as a part of the annual enrollment period after the beginning of the new Plan year.

### AUTOMATIC RE-ENROLLMENT IN THE ASSOCIATES' MEDICAL PLAN OPTIONS

If you currently have medical coverage and continue to be eligible for your current coverage, but do not actively enroll during annual enrollment, you will be automatically re-enrolled in coverage options closest to what you have currently, as described in the annual enrollment materials and posted online at WalmartOne.com, on the WIRE or on Workday during annual enrollment. This includes the eligible dependents you have elected to cover, unless you change your prior elections. You may call People Services at 800-421-1362 for more information.

You may change or drop your coverage during annual enrollment. If you do not actively enroll during annual enrollment and are automatically enrolled in a coverage plan, you will not be able to change this coverage once the annual enrollment period concludes, unless you experience a status change event or until the next annual enrollment period.

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

**NOTE:** An important exception to the automatic re-enrollment terms described above applies to all associates from newly merged eCommerce groups who were not previously enrolled under Walmart-sponsored medical coverage. For the 2018 plan year, all such associates must actively complete an online enrollment session at WalmartOne.com, on the WIRE or on Workday in order to have coverage in 2018.

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IMPORTANT

If you are a first-time enrollee, you must actively complete an online enrollment session at WalmartOne.com, on the WIRE or on Workday to receive the tobacco-free rates. For more information, see Tobacco rates in this chapter.

## When coverage is effective

The charts on the following pages describe when coverage for benefits becomes effective. You must be actively at work on the day your coverage is effective for coverage to begin. If you are not at work on the day your coverage for medical, vision, dental, critical illness insurance, accident insurance and AD&D benefits becomes effective, your coverage will begin as long as you have reported for your first day of work, enrolled for the benefit and paid the applicable premiums. If you have enrolled in optional associate life insurance, optional dependent life insurance, short-term disability (STD) enhanced plan and/or long-term disability, those coverages will not begin until you have returned to work. No enrollment is required for Resources for Living, business travel accident, STD basic plan or company-paid life insurance.

If you are not actively at work, as described below, for any reason other than a scheduled vacation on the effective date of your coverage, it will be delayed until you return to active work. If you are an associate in Hawaii, information regarding eligibility and benefits is described in the Eligibility and benefits for associates in Hawaii chapter.

### "ACTIVE WORK" OR "ACTIVELY AT WORK"

For medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources for Living coverage, "active work" (or "actively at work") means you are on active status and have reported to your first day of work at Walmart, even if you are not at work the day coverage begins (for example, due to illness).

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance and all types of disability coverage, being actively at work means you are actively at work with the company on a day that is one of your scheduled work days and performing all of the regular duties of your job on a full-time basis or 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.

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### DELAY OF COVERAGE

If you are on a leave of absence when your coverage is scheduled to become effective, your company-paid life insurance, optional associate life insurance, optional dependent life insurance, short-term disability and long-term disability coverages will be delayed until you return to active work. Your coverage options for medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources for Living will not be delayed as long as you have reported to your first day of work.

## Effective dates for benefits under the Plan

The following Enrollment and effective dates by job classification charts provide your coverage effective dates if you enroll during your initial enrollment period. If you do not enroll during your initial enrollment period, you may enroll during annual enrollment or if you experience a status change event, as described in the section titled Changing your benefits during the year: status change events later in this chapter. If you are an associate in Hawaii, see Eligibility and benefits for associates in Hawaii.



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# Enrollment and effective dates by job classification

FULL-TIME HOURLY ASSOCIATES

Includes pharmacists (except California pharmacists*), field Logistics, field supervisor positions in stores and clubs; excludes Vision Center managers

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>The first day of the calendar month during which your 89th day of continuous full-time employment falls. |
| • Company-paid life insurance | Automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls. |
| • Business travel accident insurance<br>• Resources for Living | Automatically enrolled on your date of hire. |
| • Short-term disability basic plan (not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) | Automatically enrolled at your 12-month anniversary. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous full-time employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |
| • Short-term disability enhanced plan (not available in California and Rhode Island; different coverage is available in Hawaii and New Jersey; New York short-term disability enhanced plan is available in New York)<br>• Long-term disability (LTD) plan<br>• LTD enhanced plan | **Initial enrollment period:**<br>Between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls.<br>**When coverage is effective:**<br>• **If your hire date is December 31, 2015, or before, and:**<br>- **You enroll during your initial enrollment period:** Coverage is effective as of the first day of the calendar month during which your 89th day of continuous full-time employment falls.<br>- **You enroll after your initial enrollment period:** Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)<br>• **If your hire date is January 1, 2016, or after, and:**<br>- **You enroll during your initial enrollment period:** Coverage is effective as of your 12-month anniversary date.<br>- **You enroll after your initial enrollment period:** Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) |

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

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

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FULL-TIME HOURLY VISION CENTER MANAGERS

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>Your date of hire. |
| • Company-paid life insurance<br>• Business travel accident insurance<br>• Resources for Living<br>• Short-term disability basic plan (not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |
| • Short-term disability enhanced plan (not available in California and Rhode Island; different coverage is available in Hawaii and New Jersey; New York STD enhanced plan is available in New York)<br>• Long-term disability (LTD) plan<br>• LTD enhanced plan | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>**If you enroll during your initial enrollment period:** Coverage is effective as of your date of hire.<br>**If you enroll after your initial enrollment period:** Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) |

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

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METRO PROFESSIONAL NON-EXEMPT ASSOCIATES

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>Your date of hire. |
| • Company-paid life insurance<br>• Business travel accident insurance<br>• Resources for Living<br>• Short-term disability plan | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>**If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>**If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |
| • Long-term disability (LTD) plan<br>• LTD enhanced plan | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>**If you enroll during your initial enrollment period:** Coverage is effective as of your date of hire.<br>**If you enroll after your initial enrollment period:** Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) |

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

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical*<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between your 52-week anniversary date and the first day of the second calendar month following your 52-week anniversary date (or 60 days from your anniversary date).<br>**When coverage is effective:**<br>The first day of the second calendar month following your 52-week anniversary date.*<br>*To be eligible for medical coverage, part-time hourly and temporary associates must work the required number of hours and pass the initial or annual benefits eligibility check (whichever is applicable) described under Associate eligibility earlier in this section. Part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement. |
| • Business travel accident insurance<br>• Resources for Living | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between your 52-week anniversary date and the first day of the second calendar month following your 52-week anniversary date (or 60 days after your anniversary).<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the second calendar month following your 52-week anniversary date.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |

**NOTE:** Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates.

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PART-TIME TRUCK DRIVERS

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• Critical illness insurance<br>• Accident insurance<br>• AD&D | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>The first day of the calendar month during which your 89th day of continuous employment falls. |
| • Business travel accident insurance<br>• Resources for Living | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |

Part-time truck drivers are not subject to the benefits eligibility checks described earlier in this chapter.

**NOTE:** Part-time truck drivers may only cover their eligible dependent children and may not cover their spouses/partners. Disability coverage and company-paid life insurance are not available to part-time truck drivers.

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

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical<br>• HMO plans<br>• Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>Your date of hire. |
| • Company-paid life insurance<br>• Business travel accident insurance<br>• Resources for Living<br>• Short-term disability plan** | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but, Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |
| • Long-term disability (LTD) plan<br>• LTD enhanced plan<br>• Truck driver LTD plan<br>• Truck driver LTD enhanced plan | **Initial enrollment period:**<br>Between the date of your first paycheck and prior to your 60th day after your date of hire.<br>**When coverage is effective:**<br>**If you enroll during your initial enrollment period:** Coverage is effective as of your date of hire.<br>**If you enroll after your initial enrollment period:**<br>• **LTD plan:** Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)<br>• **Truck driver LTD plan:** You will be required to provide Evidence of Insurability; coverage is effective the first day of the pay period after People Services receives approval from Liberty. |

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

**The salaried and truck driver short-term disability plans are not covered by ERISA and are not part of the Associates' Health and Welfare Plan.

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

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## Paying for your benefits

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

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

If you are enrolled in the HSA Plan, you may also contribute to a Health Savings Account on a pretax basis, if you do not have other disqualifying coverage. See the Health Savings Account chapter for more information.

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

It's important to check your paycheck stub to be sure that the proper deductions are being taken. Remember, you can view your paycheck stub online the Monday before payday by going to Online Paystub on WalmartOne.com or the WIRE. If you believe the coverage and deductions you selected are not correct on your paycheck stub, call People Services immediately at 800-421-1362. Requests for a review of premiums paid will be considered if submitted within one year from the date of a possible overpayment. A premium reconciliation up to a maximum of one year will be completed.

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

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

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

**IMPORTANT NOTE ABOUT TAX CONSEQUENCES OF PARTNER BENEFITS**

Partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical (including the HRA) coverage that relates to your partner, or your partner's child(ren), generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the company, the company reserves the right to collect the employee FICA tax liability directly from you.

The above rules will not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code.

## Tobacco rates

You can receive lower tobacco-free rates for medical and prescription drug coverage, optional associate life insurance, optional dependent life insurance for a spouse and critical illness insurance if:

- You and/or a covered spouse/partner do not use tobacco and are considered to be "tobacco free," or
- You and/or a covered spouse/partner use tobacco and you will enroll in and complete participation in a quit-tobacco program of your choice between the time of annual enrollment and December 31, 2018; or, in the alternative, if you call Healthways, the administrator of Walmart's Quit Tobacco program, at 866-577-7169, Healthways will work with you (and, if you wish, your doctor) to find a program that is right for you.

"Tobacco free" means that you (and/or your covered spouse/partner) do not use tobacco in any form — cigarettes, cigars, pipes, snuff or chewing tobacco. For purposes of establishing tobacco-free rates, being "tobacco free" also means that you do not use e-cigarettes or any such nicotine-delivery devices.

The statement below is shown on the screen when you enroll for benefits and answer the questions regarding tobacco use:

*"Our expectation is that you will apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment."*

To review Walmart's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on the WIRE. If we receive a report of abuse, we will conduct an ethics investigation.

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

## Benefits continuation if you go on a leave of absence

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

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

Walmart will maintain medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, AD&D and Resources for Living coverage while you are on an FMLA, personal or military leave, where such coverage was provided before the leave was taken. Coverage generally will be maintained on the same terms and conditions as if you had continued to work during the leave. You must make arrangements by contacting People Services at 800-421-1362 to pay your premiums during your leave. If you cancel your coverage during your FMLA, personal or military leave and return to work, you may contact People Services at 800-421-1362 within 60 days of returning to work to reinstate your coverage. See the If you go on a leave of absence section in the respective chapters for each of the above-named benefits to learn more.

You may continue or suspend coverage for yourself and/or your eligible dependents while you are on military leave. You may also have a right to reinstate coverage upon your return. Contact People Services at 800-421-1362.

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

You should contact a member of your management team or Sedgwick for additional information about FMLA, personal or military leave, or refer to Walmart's Leave of Absence Policy on the WIRE for more specific information. You may also contact your personnel representative if you have questions about the application of the FMLA, personal or military leave policy.

### PAYING FOR BENEFITS WHILE ON A LEAVE OF ABSENCE

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

- Medical
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Optional associate life insurance
- Optional dependent life insurance
- Accidental death and dismemberment (AD&D).

When you make your payments, you are paying for coverage for the previous pay period. Thus, you may experience an interruption in the payment of medical, dental, pharmacy, vision, critical illness insurance, accident insurance, life insurance and AD&D claims. To avoid any interruption, you can pay for coverage in advance when you pay your regular premium. For more information, call People Services at 800-421-1362.

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

Walmart People Services
P.O. Box 1039
Department 3001
Lowell, Arkansas 72745

To ensure proper credit when you send payment, please be sure to include your name, insurance ID number (found on your plan ID card) and facility number. If you have HMO coverage, include your WIN (Walmart ID) number.

You may also pay by debit or credit card with a Visa, MasterCard or Discover card by calling 800-421-1362 and saying "make a payment."



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If you are on a leave of absence and you owe payments for benefits to the Plan, any check issued by the company, including during or after your leave of absence (i.e., vacation, incentive, etc.), will have the full amount of premiums deducted. Payment arrangements can also be made by notifying People Services prior to your return to work. Generally, payments to continue your coverage can only be accepted from you, a family member, including a partner, or a health care provider.

If your coverage is canceled, please see the applicable benefit section for information about reinstating coverage.

## Benefits continuation if you have an approved disability claim

If an unplanned illness or injury prevents an associate from being able to do his or her job, the company provides disability coverage options for certain eligible associates. The disability chapters of this Summary Plan Description describe plan eligibility and details of coverage. For details regarding your responsibility for paying for benefits in the event you have an approved disability claim, refer to the **Continuing benefit coverage while disabled** section of each of those chapters.

## Changing your benefits during the year: status change events

Certain benefits can be changed at any time during the year, but others can be changed only during annual enrollment or if you have a status change event, as follows:

- Optional associate life insurance and optional dependent life insurance can be added or dropped at any time.
- The Associates' Medical Plan, HMO plans, the eComm PPO Plan, dental, vision, AD&D, critical illness insurance and accident insurance can be changed only during annual enrollment unless you have a status change event.
- Short-term disability enhanced, long-term disability and truck driver long-term disability can be dropped at any time. (The the change will be effective the day after you drop coverage.) They can be added only at annual enrollment unless you have a status change event.

Federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year for which the choice was made. This does not apply to pretax contributions to a Health Savings Account, which can be changed at any time.

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

Status change events include:

- Events that change your marital status:
  - Marriage
  - Death of your spouse
  - Divorce (including the end of a common-law marriage in states where a divorce decree is required to end a recognized common-law marriage)
  - Annulment, or
  - Legal separation.
- Events that change your domestic partnership status:
  - Commencement of domestic partnership
  - Termination of domestic partnership, or
  - Death of your domestic partner.
- Events that change the status of a legal relationship with a person other than a spouse or domestic partner, as specified in the definition of spouse/partner:
  - Commencement of legal relationship
  - Termination of legal relationship, or
  - Death of the other person to whom you are joined in legal relationship.
- Events that change the number of your dependents:
  - Birth
  - Adoption
  - Placement for adoption
  - Death of a dependent
  - Gain of custody of a dependent
  - Loss of custody of a dependent for whom you have previously been awarded legal custody or guardianship by a judge
  - Your paternity test result, or
  - When a dependent loses eligibility, such as at the end of the month in which the dependent reaches age 26.
- Employment changes experienced by you, your spouse/partner or your dependent:
  - Going on or returning from an approved leave of absence
  - Gain or loss of coverage due to starting or ending employment

- A change in work location that affects your medical coverage. If the change affects your medical coverage plan options (such as if a new HMO, the Accountable Care Plan, the Select Network Plan or the eComm PPO Plan is offered), you will have 60 calendar days from your transfer to submit a request to change your coverage. If you transfer work locations where your medical benefits are affected and do not submit a request, you will automatically be enrolled in a predetermined plan
- If you, your spouse/partner or your dependent(s) gain or lose coverage under any other employer plan, you may change your coverage in a manner consistent with the change. For example, if your spouse/partner enrolls in or drops coverage during an annual enrollment at his or her place of employment or due to a status change event, you may change your coverage in a manner consistent with your spouse/partner's change in coverage, or
- If you are a part-time hourly or temporary associate and your hours are reduced such that you work an average of less than 30 hours per week (regardless of whether the reduction in hours affects your eligibility for medical benefits) and you intend to enroll in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that your medical coverage under the Plan would end, you may drop coverage in the Associates' Medical Plan or an HMO plan or the eComm PPO Plan.

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### LOSS OF COVERAGE

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

### GAIN OF OTHER COVERAGE

- If an order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order — See **Qualified Medical Child Support Orders (QMCSO)** later in this chapter) requires you to provide medical, dental and/or vision coverage for your eligible dependent child(ren), you may add coverage for your eligible dependent child(ren) (and yourself, if you are not already covered). If the order requires your spouse, former spouse or other person to provide medical, dental and/or vision coverage for your dependent child(ren), and that other coverage is in fact provided, you may drop coverage for the dependent child(ren).
- If you are eligible for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual enrollment period, you can drop coverage in the Associates' Medical Plan, an HMO plan or the eComm PPO Plan, in accordance with rules set forth by the Department of Health and Human Services. You and any dependents who cease coverage under the Plan must provide evidence of your enrollment rights and state that you intend to enroll in a qualified health plan through a Marketplace effective no later than the day immediately following the last day of your coverage under the Associates' Medical Plan, HMO plan or eComm PPO Plan.
- If you, your spouse/partner or your eligible dependents are enrolled in the Associates' Medical Plan, an HMO plan, the eComm PPO Plan, accident insurance or critical illness insurance, you can drop that coverage if you, your spouse/partner or your dependents become entitled to Medicare or Medicaid benefits.
- If you, your spouse/partner or your eligible dependents gain eligibility under a governmental plan (other than Medicare, Medicaid or TRICARE), you cannot drop the Associates' Medical Plan, an HMO plan, the eComm PPO Plan, accident insurance or critical illness insurance coverage except during annual enrollment.
- If you, your spouse/partner or your eligible dependents become eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request coverage under the Plan within 60 days of becoming eligible for assistance.

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### ADDITIONAL CIRCUMSTANCES IN WHICH YOU MAY CHANGE YOUR BENEFITS

In addition to the circumstances under which you may change your benefits listed above, there are additional circumstances, including cost changes, reduction of coverage, and/or additions/improvements of a benefit option, in which the Plan, in its sole discretion, may allow you to make mid-year changes to your elections. For more information, contact People Services at 800-421-1362.

## Making changes in your coverage as a result of status change events

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

Unless otherwise provided in the Plan, if you add a spouse or partner (as such term is defined above) or other eligible dependent due to a status change event, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to any applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options. If you change from one of the HRA plans to another during the Plan year as a result of a status change event, the amount credited to your HRA will be prorated according to the time remaining in the year. If you change from one of the HRA plans to a non-HRA plan, your HRA balance will be forfeited. See The medical plan chapter for more information.

If you are covered as a dependent and move to coverage as an associate during the Plan year, you will generally not receive credit under the Associates' Medical Plan for expenses incurred prior to the date of the change. However, if you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductibles and out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent. You will also receive credit toward any waiting periods.

When dependents are added due to a status change event or during annual enrollment, each Plan participant will be subject to a one-year wait before becoming eligible for benefits such as the transplant and the weight loss surgery benefit.

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

### HIPAA SPECIAL ENROLLMENT FOR MEDICAL COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you also may have a right to a special enrollment in medical coverage under the Plan if you lose other coverage or acquire a dependent. These events are described in the list of status change events and include:

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself, and if you choose, yourself and your dependents in this Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. You must request enrollment within 60 days.
- If you or a dependent is no longer eligible for coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, or you or a dependent becomes eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request enrollment within 60 days of the prior coverage terminating or your becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the Plan.
- To request special enrollment or obtain more information, refer to the information in this chapter regarding status change events or contact People Services at 800-421-1362.

**HOW TO CHANGE YOUR ELECTIONS DUE TO A STATUS CHANGE EVENT**

You can make changes online within 60 days on the WIRE, WalmartOne.com or Workday for status changes due to:

- Adoption
- Birth
- Commencement of domestic partnership as defined under Dependent eligibility earlier in this chapter
- Commencement of legal relationship with a person other than your spouse or domestic partner
- Death of spouse/partner
- Divorce or legal separation
- Gain of custody
- Gain or loss of coverage by you, your dependent(s) or your eligible spouse/partner
- Going on leave of absence
- Marriage
- Returning from leave of absence
- Special enrollment period
- Termination of domestic partnership, or
- Termination of legal relationship with a person other than a spouse or domestic partner.

For all other types of status changes, call People Services at 800-421-1362.

If your status change event is the birth of a dependent, the Plan will accept provider billing charges related to the birth as notice that the newborn is to be added as a dependent under your coverage, so long as the charges are submitted within 60 days of the birth.

If you are seeking to add a dependent as a result of marriage, commencement of a domestic partnership or commencement of a legal relationship with a person other than a spouse or domestic partner, but the individual to be added as a dependent dies before you have provided notice of the status change event, the individual will not be added to your coverage as a dependent.

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

This does not apply to optional associate life insurance, optional dependent life insurance, STD enhanced plan coverage, long-term disability or truck driver long-term disability; see the respective chapters for information about effective dates.

**NOTE:** If your status change results in an increase in your coverage costs, such as if you change from associate-only coverage to associate + dependent coverage, the increased charge will be deducted from your pay after you notify People Services of your status change event and will be retroactive to the effective date of your new coverage. These deductions will be made on an after-tax basis.

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

Also, if the status change event is due to your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical, dental and/or vision benefits if you do not notify People Services of the event within 60 days. Similarly, if the status change event is due to your divorce, the termination of a domestic partnership or the termination of a legal relationship with a person other than your spouse or domestic partner, your former spouse/partner will lose the right to elect COBRA coverage for medical, dental and/or vision benefits if People Services is not notified of the event within 60 days. See the COBRA chapter for more information.

## If your job classification changes

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

If you are classified as a part-time hourly or temporary associate and your classification is changed to full-time, you will be eligible for full-time benefits, as described in the chart on the next page.

If your job classification changes from full-time associate to part-time or temporary associate or part-time truck driver, your spouse/partner will no longer be eligible for medical, dental, vision, dependent life insurance, AD&D, critical illness or accident coverage. You and your family members will no longer be eligible for company-paid life or disability coverage. If this change results in your spouse/partner or other dependent losing coverage, see the COBRA chapter to learn how you and/or your eligible dependents may be able to continue medical, dental and vision coverage.

**NOTE:** If your job classification changes to part-time hourly or temporary associate, see the Benefits eligibility checks for part-time hourly and temporary associates section earlier in this chapter for more information.

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# Coverage effective dates when transferring from one job classification to another

## PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and will be eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey or Rhode Island, which have state-mandated disability plans. (Associates in New York will be able to enroll in the NY short-term disability enhanced plan.)<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) plan coverage.<br>• If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• If you are currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. |

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be eligible to enroll in medical coverage. See The medical plan chapter for more information.<br>• You will be enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and will be eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey or Rhode Island, which have state-mandated disability plans. (Associates in New York will be able to enroll in the NY short-term disability enhanced plan.)<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) plan coverage.<br>• If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• If you are currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. |

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have been continuously employed for more than 90 days but less than 52 weeks | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective (with the exception of short-term and long-term disability) either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information.<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• You will be eligible to enroll in the short-term disability enhanced plan and the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Depending on your hire date, your coverage under the short-term disability enhanced plan and LTD plan will be effective either on the 12-month anniversary of your hire date (for associates hired on or after January 1, 2016) or as of the date you enroll (for associates hired on or before December 31, 2015). At that time you will also be automatically enrolled in company-provided short-term disability basic coverage. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this initial enrollment period, your coverage will not be effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period will begin as of the date of the event.) |

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have been continuously employed for less than 90 days | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective (with the exception of short-term and long-term disability) as follows:<br>- If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date will be the first day of the calendar month during which your 89th day of continuous employment falls.<br>- If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date will be the date you enroll. However, if you enroll by calling People Services you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls.<br>• Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment.<br>• You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information.<br>• You will be enrolled automatically in company-paid life insurance on the first day of the calendar month during which your 89th day of continuous employment falls.<br>• If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• You will be eligible to enroll in the short-term disability enhanced plan and the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Depending on your hire date, your coverage under the short-term disability enhanced plan and LTD plan will be effective either on the 12-month anniversary of your hire date (for associates hired on or after January 1, 2016) or as of the date you enroll (for associates hired on or before December 31, 2015). At that time you will also be automatically enrolled in company-provided short-term disability basic coverage. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this initial enrollment period, your coverage will not be effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period will begin as of the date of the event.) |

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT

| If Your Transition Occurs | When Coverage Is Effective |
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| And you have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• The maximum amount of optional associate life insurance coverage you can select will increase from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health will be required.)<br>• You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) insurance. See the respective chapters in this Summary Plan Description for more information.<br>• If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• If you are currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.<br>• You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. |

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll; if you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be eligible to enroll in medical coverage and long-term disability (LTD). See the respective chapters in this Summary Plan Description for more information.<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• The maximum amount of optional associate life insurance coverage you can select will increase from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health will be required.)<br>• You will be eligible to enroll in optional dependent life insurance for your spouse/partner. See the Optional dependent life insurance chapter in this Summary Plan Description for more information.<br>• If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• If you are currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.<br>• You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. |
| And you have been continuously employed for less than 52 weeks | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance, accident insurance and long-term disability. See the respective chapters in this Summary Plan Description for more information.<br>• You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs.<br>• If you enroll for optional associate life insurance or optional dependent life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. |

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FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO MANAGEMENT

| If Your Transition Occurs | When Coverage Is Effective |
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| And you have been continuously employed for 90 days or more | • The maximum amount of optional associate life insurance coverage you can select will increase from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health will be required.)<br>• The terms of your short-term disability coverage will change as follows:<br>- You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.<br>- Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.) |
| And you have been continuously employed for less than 90 days | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll; if you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date.<br>• You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance and long-term disability insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information.<br>• If you enroll for optional associate life insurance or optional dependent life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period.<br>• The terms of your short-term disability coverage will change as follows:<br>- You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.<br>- Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.) |

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FULL-TIME HOURLY VISION CENTER MANAGERS TRANSFERRING TO MANAGEMENT

| | When Coverage Is Effective |
|---|---|
| | • The terms of your short-term disability coverage will change as follows:<br>- You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.<br>- Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.) |

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MANAGEMENT ASSOCIATES AND METRO PROFESSIONAL NON-EXEMPT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| Within 60 days of your hire date and before you have enrolled for benefits | • You will have 60 days to enroll from the date your transition in status occurs. The terms of your benefit plans as a full-time hourly associate will be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter.<br>• Premiums will be deducted from your paycheck on an after-tax basis retroactively to your coverage effective date.<br>• You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates as of your hire date (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). See the Short-term disability for hourly associates chapter for more information.<br>• If you enroll for optional associate life insurance or optional dependent life insurance, your guaranteed issue amount will become effective on your enrollment date. If you enroll for more than the guaranteed issue amount, you will have to provide Proof of Good Health for you and/or your spouse/partner, as applicable. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. |
| Within 60 days of your hire date and after you have enrolled for benefits | • You will have 60 days to make a new enrollment from the date your transition in status occurs. The terms of your benefit plans as a full-time hourly associate will generally be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter.<br>• Premiums will be deducted from your paycheck as of your coverage effective date for any new benefit election you make. For benefit plans in which you were already enrolled, premiums will be adjusted to your full-time hourly status on an after-tax basis retroactively to the date of your transition in status.<br>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.<br>• If you were not previously enrolled in optional associate life insurance or optional dependent life insurance and choose to enroll in either plan after your transition in status, your guaranteed issue amount will be effective as of your enrollment date. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates as of the date of your transition in status (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). See the Short-term disability for hourly associates chapter for more information. |
| More than 60 days after your hire date | • If you are currently enrolled for benefits, you will have 60 days to make a new enrollment from the date your transition occurs. The terms of your benefit plans as a full-time hourly associate will be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next annual enrollment period or until you have a valid status change event. If you are not currently enrolled for benefits, you cannot enroll until the next annual enrollment period or until you have a valid status change event.<br>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.<br>• You may enroll in optional associate life insurance or optional dependent life insurance at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). If you had not enrolled for benefits before your transition in status, your coverage under the LTD plan will not be effective until the 12-month anniversary of your hire date. See the Short-term disability for hourly associates and Long-term disability chapters for more information. |

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FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| And you have met your eligibility waiting period and were eligible for coverage under the Plan immediately prior to your transition | • If you are enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance coverage, your coverage type will automatically be adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents) effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time associates.<br>• Company-paid life, dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your dependent's life insurance to an individual policy. |
| But you have NOT met your eligibility waiting period | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.<br>• Your coverage will be effective as follows:<br>- If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date will be the first day of the calendar month during which your 89th day of continuous employment falls.<br>- If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date will be the date you enroll. However, if you enroll by calling People Services, you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls.<br>• Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment.<br>• You will be eligible to enroll in medical, dental, vision, AD&D, optional associate life insurance and dependent life insurance for your children, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information.<br>• If you enroll for optional associate life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.<br>• If you enrolled in the short-term disability enhanced plan for hourly associates during your initial enrollment period but you have not reached the 12-month anniversary of your hire date, coverage under the plan will not take effect as of that date.<br>• If you enrolled in the LTD or LTD enhanced plan during your initial enrollment period, coverage will not take effect.<br>• You will be eligible to enroll in associate-only or associate + child(ren) coverage types. |

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MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY

| If Your Transition Occurs | When Coverage Is Effective |
|---|---|
| Within 60 days of your hire date and before you have enrolled for benefits | • You will have 60 days to enroll from the date your transition in status occurs. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter.<br>• Premiums will be deducted from your paycheck on an after-tax basis retroactively to your coverage effective date.<br>• Company-paid life coverage will be canceled effective the first day of the pay period after your transition occurs. |
| Within 60 days of your hire date and after you have enrolled for benefits | • You will have 60 days to make a new enrollment from the date your transition in status occurs. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter.<br>• Premiums will be adjusted to your new benefit elections on an after-tax basis retroactively to your coverage effective date.<br>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.<br>• Company-paid life, optional dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your dependent's life insurance to an individual policy. |
| More than 60 days after your hire date | • If you are currently enrolled for benefits, you will have 60 days to make a new enrollment from the date your transition in status occurs. The terms of your benefit plans as a part-time hourly or temporary associate will be effective as of the date of your transition. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next annual enrollment period or until you have a valid status change event. If you are not currently enrolled for benefits, you cannot enroll until the next annual enrollment period or until you have a valid status change event.<br>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.<br>• Company-paid life, optional dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your dependent's life insurance to an individual policy |

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You will have 60 days from the date of your transition to a part-time hourly, temporary or part-time truck driver position to elect any other medical coverage option available to you and/or your dependents under the Plan. You may not drop medical, dental, AD&D, critical illness, accident or vision coverage for yourself and/or your dependent children during the Plan year. If you do not elect to change your coverage option within the 60-day enrollment period, you will continue to be covered by the same full-time medical option, but excluding spouse/partner coverage. You may change elections during any future annual enrollment period or as the result of a status change event.



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## Qualified Medical Child Support Orders (QMCSO)

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

The written procedures for determining whether an order meets the federal requirements may be obtained free of charge by contacting Medical Support Services at 877-930-5607.

Once the Plan determines an order to be a QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order, unless another date is specified in the order. Associates who are eligible for the medical, dental and/or vision plan and who did not elect coverage before the order was received will be enrolled in the 2018 default HRA Plan with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise. For associates in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA). For associates in a location where the eComm PPO Plan is offered, the default plan is the HSA Plan.

If you were enrolled for coverage before the order was received, your child will be added under your existing coverage, except if you are enrolled in an HMO plan, the Accountable Care Plan, or the Select Network Plan; if you are enrolled for coverage in any of these plans, your coverage will change to the HRA Plan, under which the child would have coverage regardless of where he or she lives. If you are in the state of Hawaii, your coverage will change to HMSA. You will have 60 days to call Medical Support Services at 877-930-5607 to select an alternative medical plan.

If the Plan receives a QMCSO 61–90 days prior to you satisfying your initial waiting period, the order will be put into effect when your initial waiting period is satisfied. If the Plan receives a QMCSO more than 90 days prior to you satisfying your initial waiting period, the order will be held until coverage takes effect.

When the Third Party Administrator is administering coverage for a court-ordered dependent, information regarding the court-ordered dependent will be shared only with the legal custodian. If you have questions, please contact Medical Support Services at 877-930-5607.

### DROPPING OR CHANGING QMCSO COVERAGE

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

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

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

When a QMCSO terminates, an associate may drop medical, dental and/or vision coverage for the children named in the QMCSO. However, you may not drop your own coverage or coverage for any dependent voluntarily added after the QMCSO became effective unless there is a change in status for you or your child(ren), or during annual enrollment. For dental coverage, you may not drop associate-level coverage at annual enrollment or due to a status change event, unless you have been covered for two full calendar years.

## When your Plan coverage ends

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

- At termination of your employment
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date of your (the associate's) death, for you and your dependents
- On the date of death for a deceased dependent
- On the date you, a dependent spouse/partner or child loses eligibility
- When the benefit is no longer offered by Walmart
- Upon misrepresentation or the fraudulent submission of a claim for benefits or eligibility
- Upon an act of fraud or a misstatement of a material fact, or
- The day after you drop coverage.

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

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# Eligibility and benefits for associates in Hawaii

## WHERE CAN I FIND?


| | |
|---|---|
| Eligibility waiting periods for medical coverage | 38 |
| Medical coverage options for Hawaii associates | 38 |
| Paying premiums during a leave of absence for Hawaii associates | 38 |
| Enrollment and effective dates for Hawaii associates | 39 |


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# Eligibility and benefits for associates in Hawaii

**As an associate in Hawaii, you have special rules for enrolling in the medical plan and two medical plan options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. Because Hawaii has a state-mandated disability plan, the company short-term disability plan for hourly associates is not an option for associates in Hawaii. Other than the eligibility and benefit differences described in this chapter, the information in this 2018 *Associate Benefits Book* applies to you.**

RESOURCES FOR HAWAII ASSOCIATES

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

## What you need to know as a Hawaii associate

- Associates in Hawaii have varying initial eligibility periods for coverage based on their employment status, as described in this chapter.
- Associates in Hawaii have two medical coverage options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. For more information about these medical options, see your personnel representative.

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## Eligibility waiting periods for medical coverage

### MANAGEMENT ASSOCIATES

For management associates in Hawaii, the eligibility terms described in the **Eligibility and enrollment** chapter are applicable; management associates and management trainees in Hawaii are eligible for medical coverage on their date of hire. For details on eligibility and enrollment in all of the benefits available under the Associates' Health and Welfare Plan, refer to the chart for management associates in the **Enrollment and effective dates by job classification** section of the **Eligibility and enrollment** chapter.

### FULL-TIME HOURLY, PART-TIME HOURLY AND TEMPORARY ASSOCIATES

Full-time hourly associates (including full-time hourly pharmacists and field supervisor positions in stores and clubs) and part-time hourly and temporary associates in Hawaii are subject to state-mandated rules governing eligibility for medical coverage. For benefits other than medical, they follow the eligibility terms described in the **Eligibility and enrollment** chapter. For details, refer to the appropriate chart under **Enrollment and effective dates for Hawaii associates** later in this chapter.

## Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

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

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

## Paying premiums during a leave of absence for Hawaii associates

Because the associate portion of your medical premium is wage-based, there will be no premium due if you are not receiving wages during an approved leave of absence. The only premium due for medical coverage while you are on an approved leave of absence with no wages will be the dependent portion of your premium. All other coverage options require payment as described in the **Eligibility and enrollment** chapter.

Under Hawaii law, Walmart is required to contribute at least 50% of the premium for your (associate) medical coverage, but not for dependent coverage. Associates are required to pay the remainder of the biweekly cost of the premium, but only up to 1.5% of their wages or 50% of the biweekly cost of the premium, whichever is less. So, for example, if your biweekly wages were $1,000 and you qualify for tobacco-free rates, you would not be required to pay more than $15 biweekly for coverage (assuming that the entire premium is at least $30 biweekly).

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# Enrollment and effective dates for Hawaii associates

FULL-TIME HOURLY ASSOCIATES
Includes full-time hourly pharmacists and field supervisor positions in stores and clubs

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>The earlier of:<br>• The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or<br>• The first day of the calendar month during which your 89th day of continuous full-time employment falls. |
| • Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>• The first day of the calendar month during which your 89th day of continuous full-time employment falls. |
| • Company-paid life insurance | Automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls. |
| • Business travel accident insurance<br>• Resources for Living | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous full-time employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |
| • Long-term disability (LTD) plan<br>• LTD enhanced plan | **Initial enrollment period:**<br>Between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls.<br>**When coverage is effective:**<br>• **If your hire date is December 31, 2015 or before, and:**<br>- **You enroll during your initial enrollment period:** Coverage is effective as of the first day of the calendar month during which your 89th day of continuous full-time employment falls.<br>- **You enroll after your initial enrollment period:** Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)<br>• **If your hire date is January 1, 2016 or after, and:**<br>- **You enroll during your initial enrollment period:** Coverage is effective as of your 12-month anniversary date.<br>- **You enroll after your initial enrollment period:** Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) |

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PART-TIME HOURLY AND TEMPORARY ASSOCIATES

| Plan | Enrollment Periods and Effective Dates |
|---|---|
| • Medical* | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>The earlier of:<br>• The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or<br>• The first day of the calendar month during which your 89th day of continuous employment falls.<br>* Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under Part-time hourly and temporary associates: eligibility checks for medical coverage in the Eligibility and enrollment chapter. |
| • Vision<br>• Dental (enrollment is for two full calendar years)<br>• AD&D<br>• Critical illness insurance<br>• Accident insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>The first day of the calendar month during which your 89th day of continuous employment falls. |
| • Business travel accident insurance<br>• Resources for Living | Automatically enrolled on your date of hire. |
| • Optional associate life insurance<br>• Optional dependent life insurance | **Initial enrollment period:**<br>Between the date of your first paycheck and the day prior to your effective date, as described immediately below.<br>**When coverage is effective:**<br>• **If you enroll during your initial enrollment period:** Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.<br>• **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential. |

**NOTE:** Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates

**Management associates:** Refer to the chart for management associates in the Enrollment and effective dates by job classification section of the Eligibility and enrollment chapter.

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# The medical plan

## WHERE CAN I FIND?


| | |
|---|---|
| The Associates' Medical Plan | 45 |
| HMO plans | 52 |
| The eComm PPO Plan | 52 |
| Administration of the Associates' Medical Plan | 52 |
| The HRA High Plan, the HRA Plan and the HSA Plan | 52 |
| The Accountable Care Plan | 56 |
| The Select Network Plan | 58 |
| What is covered by the Associates' Medical Plan | 59 |
| Your provider network | 60 |
| Special provider networks | 62 |
| Preventive care program | 62 |
| Prenotification | 65 |
| Preauthorization | 65 |
| Helping you manage your health | 66 |
| Walmart Care Clinic | 68 |
| Centers of Excellence | 69 |
| When limited benefits apply to the Associates' Medical Plan | 74 |
| What is not covered by the Associates' Medical Plan | 78 |
| Filing a medical claim | 80 |
| If you have coverage under more than one medical plan | 81 |
| If you go on a leave of absence | 82 |
| When coverage ends | 83 |
| If you leave the company and are rehired | 83 |
| If you drop coverage and re-enroll | 83 |
| Other information about the medical plan | 83 |


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# The medical plan

ASSOCIATES' MEDICAL PLAN RESOURCES

| Find What You Need | Online | By Phone: Health Care Advisor | Other Resources |
|---|---|---|---|
| **Third Party Administrator** | Go to WalmartOne.com or | | |
| Aetna | aetna.com | 855-548-2387 | Aetna<br>151 Farmington Avenue<br>Hartford, Connecticut 06156 |
| BlueAdvantage Administrators of Arkansas | blueadvantagearkansas.com | 866-823-3790 | BlueAdvantage Administrators of Arkansas<br>P.O. Box 1460<br>Little Rock, Arkansas 72203-1460 |
| HealthSCOPE Benefits | healthscopebenefits.com | 800-804-1272 | HealthSCOPE Benefits<br>P.O. Box 16367<br>Lubbock, Texas 79490-6367 |
| UnitedHealthcare | myuhc.com | 888-285-9255 | UnitedHealthcare<br>P.O. Box 30555<br>Salt Lake City, Utah 84130-0555 |
| Locate a network provider | Go to the WIRE or WalmartOne.com | Call your health care advisor at the number on your plan ID card | |
| If you have questions about how your medical benefits are administered | | Call your health care advisor at the number on your plan ID card | |
| Get the cost for medical coverage | Go to the WIRE or WalmartOne.com | Call People Services at 800-421-1362 | |
| Medical advice from a registered nurse, available 24/7 | | Call your health care advisor at the number on your plan ID card | |
| For information on the Walmart Centers of Excellence program | Go to the WIRE or WalmartOne.com | Call your health care advisor at the number on your plan ID card | |
| For information on telehealth options | Go to the WIRE or WalmartOne.com | Call your health care advisor at the number on your plan ID card | |
| For information on the Walmart Care Clinic | WalmartCareClinic.com | Call People Services at 800-421-1362 | |
| Castlight Health: For help finding medical care based on cost information and user reviews | Go to the WIRE or WalmartOne.com or directly to MyCastlight.com/Walmart | Call your health care advisor at the number on your plan ID card | |
| For guidance from the Life with Baby program or comparable maternity program | | Call your health care advisor at the number on your plan ID card | |
| Request a paper copy of this 2018 *Associate Benefits Book* | | Call People Services at 800-421-1362 | |

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# What you need to know about medical benefits

- Under the Associates' Medical Plan, most eligible associates have the option to choose medical coverage under the HRA High Plan, the HRA Plan or the HSA Plan. In select regions, the HRA High Plan option is replaced by an Accountable Care Plan or by the Select Network Plan. This chapter describes how all these plans function and where they are available. If you have questions about how your medical benefits are administered, call your health care advisor at the number on your plan ID card.
- If you enroll in any of the plan options available under the Associates' Medical Plan, you'll be able to call your health care advisor — a single point of contact for a wide range of health benefit needs. This expert resource can help you work with network doctors and answer questions about your health care benefits. Plus, in some cases you'll be assigned a single, dedicated nurse care manager to help with all of your family's medical needs and questions.
- The HRA High Plan and the HRA Plan include a Health Reimbursement Account (HRA). An HRA is an "account" to which the company allocates a specified sum of money to help pay your eligible medical expenses before you have to pay for care out of your own pocket. (Your HRA is used to pay for all eligible care except for prescription drugs.) This chapter describes how company-provided dollars allocated to your HRA can help pay for eligible medical expenses.
- The HSA Plan allows you to open a Health Savings Account where you can make contributions through payroll deduction, which you can save or use to pay for eligible medical expenses (as defined by the IRS) on a tax-free basis. Walmart will match your contributions up to predetermined limits. For more information about a Health Savings Account, see the **Health Savings Account** chapter.
- The plan options available under the Associates' Medical Plan have no annual or lifetime maximum dollar limits.
- The Associates' Medical Plan does not have a pre-existing condition limitation.
- Walmart also offers HMO (Health Maintenance Organization) plans in 12 states and the District of Columbia. Refer to your personnel representative to find out if an HMO is available in your area and to request HMO plan information.
- Walmart also offers the eComm PPO Plan to associates in some locations. If the eComm PPO Plan is available at your work location, the plan benefits and terms are described in materials provided separately by Aetna, the Plan's Third Party Administrator.
- The Associates' Medical Plan provides prescription drug coverage through the pharmacy benefit. For more information, see **The pharmacy benefit** chapter.
- For information on benefits for localized associates, see **Localized associates** in the **Eligibility and enrollment** chapter.

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## The Associates' Medical Plan

The Associates' Medical Plan offers most eligible associates the option to enroll in one of three medical plan options that are generally available nationwide: the HRA High Plan, the HRA Plan and the HSA Plan. The Associates' Medical Plan also offers an Accountable Care Plan option to associates in select regions and the Select Network Plan to associates in select regions. Associates in regions served by an Accountable Care Plan or the Select Network Plan will not have access to the HRA High Plan, with the exception of portions of Arkansas, where the HRA High Plan will remain available. See your enrollment materials for details.

The chart below summarizes the coverage offered by the HRA High Plan, the HRA Plan and the HSA Plan. The charts on the next several pages summarize the coverage offered by the Accountable Care Plan options and the Select Network Plan. The sections that follow explain the important features of all the available plan options.

NATIONALLY AVAILABLE MEDICAL PLAN OPTIONS

| | HRA High Plan | | HRA Plan | | HSA Plan | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual deductible**<br>Associate only<br>Associate + dependent(s)<br>*Applies for all services except as noted*<br>*Does not apply to eligible preventive care* | $1,750<br>$3,500 | $3,500<br>$7,000 | $2,750<br>$5,500 | $5,500<br>$11,000 | $3,000<br>$6,000 | $6,000<br>$12,000 |
| **Walmart-provided dollars**<br>Associate only<br>Associate + dependent(s) | $500<br>$1,000<br>*Maximum company contribution to HRA* | | $300<br>$600 | | $350<br>$700<br>*Maximum company matching contribution to Health Savings Account* | |
| **Annual out-of-pocket maximum** | $6,850<br>Per person<br>$13,700<br>Per family | None | $6,850<br>Per person<br>$13,700<br>Per family | None | $6,650<br>Per person<br>$13,300<br>Per family | None |
| **Eligible preventive care** | 100%<br>*No deductible* | 50%<br>*No deductible* | 100%<br>*No deductible* | 50%<br>*No deductible* | 100%<br>*No deductible* | 50%<br>*No deductible* |
| **Doctor visits and diagnostic tests** | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* |
| **Hospitalization**<br>Inpatient, emergency, outpatient | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* |
| **Behavioral health**<br>(Inpatient and outpatient) | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* | 75%<br>*After deductible* | 50%<br>*After deductible* |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* | N/A | 75%<br>*After deductible* | N/A | 75%<br>*After deductible* | N/A |
| **Pharmacy** | See The pharmacy benefit chapter for details about your prescription drug coverage. | | | | | |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. | | | | | |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. | | | | | |

## THE ACCOUNTABLE CARE PLAN OPTIONS

Accountable Care Plan options are available to associates who work in designated regions, and their dependents, as listed in the following chart:

| PLAN | AVAILABLE FOR ASSOCIATES WHO WORK AT DESIGNATED FACILITIES IN THESE AREAS | THIRD PARTY ADMINISTRATOR |
|---|---|---|
| Banner Accountable Care Plan | Phoenix, Arizona metropolitan area | Aetna |
| Emory Accountable Care Plan | Atlanta, Georgia metropolitan area | HealthSCOPE Benefits |
| Mercy Arkansas Accountable Care Plan | Portions of Arkansas and McDonald County, Missouri | HealthSCOPE Benefits |
| Mercy Oklahoma Accountable Care Plan | Oklahoma City metropolitan area, Ada, and Ardmore areas | HealthSCOPE Benefits |
| Mercy Springfield Accountable Care Plan | Springfield, southwest and east-central Missouri | HealthSCOPE Benefits |
| Mercy St. Louis Accountable Care Plan | St. Louis metropolitan area and portions of eastern Missouri | HealthSCOPE Benefits |
| Presbyterian Accountable Care Plan | Albuquerque and Santa Fe, New Mexico metropolitan areas | UnitedHealthcare |
| St. Luke's Accountable Care Plan | Boise, Idaho metropolitan area | Aetna |
| UnityPoint Accountable Care Plan | Portions of Iowa, western Illinois and Peoria, Illinois area | HealthSCOPE Benefits |

The Accountable Care Plan options are served by groups of providers who offer care that is specifically coordinated to the needs of participants to ensure that covered individuals get the right high-quality care at the right time. The Plan's terms for paying providers for their services may include financial incentives to manage care. Additional information about the Accountable Care options and where they are available can be found under The Accountable Care Plan later in this chapter.

The following charts summarize the coverage available under the Accountable Care Plan options. In the designated areas where an Accountable Care Plan option is available, it will generally replace the HRA High Plan as a coverage option for associates who work at facilities in those areas. In other words, if you elect medical coverage under the Associates' Medical Plan in any of these areas, you will be able to choose coverage under the HRA Plan, the HSA Plan or the Accountable Care Plan, but in most areas you will not be able to choose the HRA High Plan. The exception is Arkansas, where an Accountable Care Plan option is available and associates will continue to have access to the HRA High Plan.

The Accountable Care Plan does not cover the services of doctors, hospitals or other providers who are not in the Accountable Care Plan's network, except in cases of emergency (as defined by the Third Party Administrator). Note, however, that participants enrolled in an Accountable Care Plan option are eligible to participate in the Centers of Excellence program.

For details about coverage under the Accountable Care Plan options, see The Accountable Care Plan later in this chapter.

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BANNER ACCOUNTABLE CARE PLAN

| | In-Network Benefits Only<br>*No benefits for services provided outside the network except for emergency services* |
|---|---|
| **Annual deductible**<br>Associate only<br>Associate + dependent(s)<br>*Does not apply to eligible preventive care* | <br>$3,000<br>$6,000 |
| **Annual out-of-pocket maximum** | $6,850 Per person<br>$13,700 Per family |
| **Eligible preventive care** | 100%<br>*No deductible* |
| **Doctor visits**<br>*Including routine same-day diagnostic x-rays and tests performed in the doctor's office* | |
| Primary care physician (PCP) office visit | $35 copay |
| Specialist office visit | $75 copay |
| Behavioral health office visit | $35 copay |
| Urgent care visit | $75 copay |
| **Diagnostic tests**<br>All nonpreventive tests ordered or performed outside a doctor's office | 75%<br>*After deductible* |
| **Hospitalization**<br>Inpatient, emergency, outpatient | 75%<br>*After deductible* |
| **Behavioral health**<br>Inpatient and outpatient<br>*See above for doctor visits* | 75%<br>*After deductible* |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* |
| **Pharmacy** | See The pharmacy benefit chapter for details. |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. |

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EMORY, MERCY ARKANSAS, MERCY OKLAHOMA, MERCY ST. LOUIS, ST. LUKE'S AND UNITYPOINT ACCOUNTABLE CARE PLANS

| | In-Network Benefits Only<br>*No benefits for services provided outside the network except for emergency services* |
|---|---|
| **Annual deductible**<br>Associate only<br>Associate + dependent(s)<br>*Does not apply to eligible preventive care* | $1,750<br>$3,500 |
| **Annual out-of-pocket maximum** | $6,850 Per person<br>$13,700 Per family |
| **Eligible preventive care** | 100%<br>*No deductible* |
| **Doctor visits***<br>*Including routine same-day diagnostic x-rays and tests performed in the doctor's office* | |
| Primary care physician (PCP) office visit | $35 copay |
| Specialist office visit* | $75 copay |
| Behavioral health office visit | $35 copay |
| Urgent care visit | $75 copay |
| **Diagnostic tests**<br>All nonpreventive tests ordered or performed outside a doctor's office | 75%<br>*After deductible* |
| **Hospitalization**<br>Inpatient, emergency, outpatient | 75%<br>*After deductible* |
| **Behavioral health**<br>Inpatient and outpatient<br>*See above for doctor visits* | 75%<br>*After deductible* |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* |
| **Pharmacy** | See The pharmacy benefit chapter for details. |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. |

*The Mercy Accountable Care Plans for Arkansas, Oklahoma and St. Louis, Missouri offer limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

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MERCY SPRINGFIELD ACCOUNTABLE CARE PLAN

| | In-Network Benefits Only<br>*No benefits for services provided outside the network except for emergency services* |
|---|---|
| **Annual deductible**<br>Associate only<br>Associate + dependent(s)<br>*Does not apply to eligible preventive care* | $3,000<br>$6,000 |
| **Annual out-of-pocket maximum** | $6,850 Per person<br>$13,700 Per family |
| **Eligible preventive care** | 100%<br>*No deductible* |
| **Doctor visits**<br>*Including routine same-day diagnostic x-rays and tests performed in the doctor's office* | |
| Primary care physician (PCP) office visit | $35 copay |
| Specialist office visit* | $75 copay |
| Behavioral health office visit | $35 copay |
| Urgent care visit | $75 copay |
| **Diagnostic tests**<br>All nonpreventive tests ordered or performed outside a doctor's office | 75%<br>*After deductible* |
| **Hospitalization**<br>Inpatient, emergency, outpatient | 75%<br>*After deductible* |
| **Behavioral health**<br>Inpatient and outpatient<br>*See above for doctor visits* | 75%<br>*After deductible* |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* |
| **Pharmacy** | See The pharmacy benefit chapter for details. |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. |

*The Mercy Springfield Accountable Care Plan offers limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

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PRESBYTERIAN ACCOUNTABLE CARE PLAN

| | In-Network Benefits Only<br>*No benefits for services provided outside the network except for emergency services* | |
|---|---|---|
| **Annual deductible**<br>Associate only<br>Associate + dependent(s)<br>*Does not apply to eligible preventive care* | $3,000<br>$6,000 | |
| **Annual out-of-pocket maximum** | $6,850 Per person<br>$13,700 Per family | |
| **Eligible preventive care** | 100%<br>*No deductible* | |
| **Doctor visits***<br>*Including routine same-day diagnostic x-rays and tests performed in the doctor's office* | Presbyterian Tier 1 | Presbyterian Tier 2 |
| Primary care physician (PCP) office visit | $35 copay | 75%<br>*After deductible* |
| Specialist office visit | $75 copay | |
| Behavioral health office visit | $35 copay | |
| Urgent care visit | $75 copay | |
| **Diagnostic tests**<br>All nonpreventive tests ordered or performed outside a doctor's office | 75%<br>*After deductible* | |
| **Hospitalization**<br>Inpatient, emergency, outpatient | 75%<br>*After deductible* | |
| **Behavioral health**<br>Inpatient and outpatient<br>*See above for doctor visits* | 75%<br>*After deductible* | |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* | |
| **Pharmacy** | See The pharmacy benefit chapter for details. | |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. | |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. | |

*For details about the Presbyterian Accountable Care Plan's network coverage for doctor visits, see If you have coverage under the Presbyterian Accountable Care Plan later in this chapter.

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## THE SELECT NETWORK PLAN

The Select Network Plan is administered by Aetna and available to associates who work in designated regions. The chart below summarizes the coverage under the Plan. In each of the areas where the Select Network Plan is available, it will replace the HRA High Plan as a coverage option for associates. In other words, if you elect medical coverage under the Associates' Medical Plan in any of the areas where the Select Network Plan is available, you will be able to choose coverage under the HRA Plan, the HSA Plan or the Select Network Plan, but you will not be able to choose the HRA High Plan.

The Select Network Plan does not cover the services of doctors, hospitals or other providers who are not in the Select Network (even if they are located in the Select Network Plan's service area), except in cases of emergency (as defined by the Third Party Administrator). Note, however, that participants enrolled in the Select Network Plan are eligible to participate in the Centers of Excellence program.

For details about coverage under the Select Network Plan see The Select Network Plan later in this chapter.

THE SELECT NETWORK PLAN

| | In-Network Benefits Only<br>*No benefits for services provided outside the network except for emergency services* |
|---|---|
| Annual deductible<br>Associate only<br>Associate + dependent(s)<br>*Does not apply to eligible preventive care* | <br>$2,750<br>$5,500 |
| **Annual out-of-pocket maximum** | $6,850 Per person<br>$13,700 Per family |
| **Eligible preventive care** | 100%<br>*No deductible* |
| **Doctor visits**<br>*Including routine same-day diagnostic x-rays and tests performed in the doctor's office* | |
| Primary care physician (PCP) office visit | $35 copay |
| Specialist office visit | $75 copay |
| Behavioral health office visit | $35 copay |
| Urgent care visit | $75 copay |
| **Hospitalization** | 75%<br>*After deductible* |
| **Behavioral health**<br>(Inpatient and outpatient)<br>*See above for doctor visits* | 75%<br>*After deductible* |
| **Telehealth video visits**<br>(Doctor On Demand) | 75%<br>*After deductible* |
| **Pharmacy** | See The pharmacy benefit chapter for details. |
| **Centers of Excellence** | See the Centers of Excellence section of this chapter for details. |
| **Walmart Care Clinic** | See the Walmart Care Clinic section of this chapter for details. |

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## HMO plans

HMO plans are available in some locations, in addition to the plans offered under the Associates' Medical Plan. If an HMO is available at your work location, the plan benefits and terms are described in materials provided separately by the HMO provider. To find out if an HMO is available to you, contact your personnel representative. The policies for HMO plans include different benefits, limitations and exclusions, cost-sharing requirements and other features than the Associates' Medical Plan. (Note that HMOs are not part of the Associates' Medical Plan.) All HMO claim issues should be directed to the HMO for resolution.

In addition, HMO plans may have different eligibility requirements than the Associates' Medical Plan. If you enroll for coverage under an HMO, the HMO plan certificate you receive will describe the HMO's eligibility terms. Please note that if there is any difference between the HMO's eligibility terms and the eligibility terms of the Associates' Medical Plan, the Plan will apply its own eligibility requirements.

Some HMOs require participants to accept an arbitration agreement, where permitted by law, before benefits under the HMO can become effective. If you enroll in an HMO and do not return the signed arbitration agreement within 60 days of your initial enrollment, your HMO benefits will not take effect.

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## The eComm PPO Plan

In addition to the medical plans offered under the Associates' Medical Plan, the eComm PPO Plan is available in some locations. If the eComm PPO Plan is available at your work location, the plan benefits and terms are described in materials provided separately by the eComm PPO Plan's Third Party Administrator. The benefits, limitations and exclusions, cost-sharing requirements and other features of the eComm PPO Plan are different from those of the Associates' Medical Plan. (Like the HMO plans, the eComm PPO Plan is not part of the Associates' Medical Plan.) The eComm PPO Plan will apply the eligibility requirements outlined in the **Eligibility and enrollment** chapter.

## Administration of the Associates' Medical Plan

The Associates' Medical Plan is self-insured. This means there is no insurance company that collects premiums and pays benefits. Instead, participating associates make contributions to cover a portion of the cost of their benefits, and the rest of the cost is paid directly from company assets or from the Plan's Trust.

Walmart contracts with Third Party Administrators (TPAs) to handle administration of the Plan options available under the Associates' Medical Plan: BlueAdvantage Administrators of Arkansas, Aetna Life Insurance Company (Aetna), UnitedHealthcare (UHC) and HealthSCOPE Benefits, Inc. Walmart also contracts with Health Design Plus to serve as the Third Party Administrator for certain procedures under the Centers of Excellence program, as described under **Centers of Excellence** later in this chapter.

Your work location and the Plan option you select will determine which TPA will administer your coverage under the Associates' Medical Plan. The TPA makes medical claim determinations and processes claims based on the Plan's terms and the TPA's policies and procedures. The TPA also provides a network of providers that accept discounted rates for services they provide to Plan participants. See **Your provider network** later in this chapter for further details.

## The HRA High Plan, the HRA Plan and the HSA Plan

### HOW THE HRA HIGH PLAN AND THE HRA PLAN PAY BENEFITS

The HRA High Plan and the HRA Plan include a Health Reimbursement Account (HRA) that is paid for by the company. Each year, Walmart will allocate money to an HRA for you and any covered family members to use toward the portion of covered medical expenses that is subject to cost-sharing, including the annual deductible. You cannot contribute your own money to the HRA. The Plan will automatically pay your share of covered medical expenses until the HRA is exhausted (except for prescription charges, which cannot be paid for with HRA dollars). The amount your HRA pays toward eligible medical expenses applies toward your network and out-of-network annual deductibles as well as your out-of-pocket maximum.

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Your HRA balance (including your Plan year allocation) may not exceed your network annual deductible for the Plan in which you are enrolled. The new Plan year allocation may be used only for services rendered within that Plan year. For example, if you enroll in one of the HRA plans and receive an allocation of HRA funds for 2018, you would be able to use those funds for services rendered in 2018 but not for services rendered prior to 2018 (such as a provider expense that you incurred in 2017 but that was not processed by the TPA until 2018). The HRA rollover balance can be utilized for any service date for which the associate was continuously enrolled in one of the HRA plans.

If you leave the company, cancel your coverage, lose eligibility or change from a plan with an HRA to one without, any funds remaining in your HRA are forfeited unless you enroll in COBRA coverage. If you enroll in COBRA coverage, your HRA balance goes with you and you will continue to receive company-provided HRA contributions. See the **COBRA** chapter for more information about COBRA continuation coverage.



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### HRA FOR MIDYEAR ENROLLMENTS

If you enroll midyear in an HRA plan (or change from one of the HRA plans to another, or from associate-only to associate + dependents coverage), Walmart will allocate a prorated amount to your HRA (although your annual deductibles and out-of-pocket maximum are not prorated). The prorated amount will equal the annual HRA amount divided by 12, multiplied by the number of months remaining in the year from the effective date of your coverage. The HRA balance may not exceed your in-network deductible. However, no change will be made to your HRA balance if you change from one HRA plan to another, or from associate + dependents coverage to associate-only coverage. If you drop HRA coverage, your HRA balance will be forfeited.

### HOW THE HRA HIGH PLAN AND THE HRA PLAN ANNUAL DEDUCTIBLES WORK

Your annual deductible is the amount you are responsible for paying each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses. You can meet your annual deductible with your Walmart-provided HRA funds from the current year and any rollover HRA dollars you may have from a previous year. When you have used all of your Walmart-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

Under the HRA High Plan and the HRA Plan, you must meet separate annual deductibles for services provided by network providers and non-network providers, as stated in the medical summary chart at the beginning of this chapter. See Your provider network later in this chapter for more information on network and non-network providers.

The amount of your deductible is based on which plan you choose and whether you are covering just yourself (associate only) or any eligible dependents as well (associate + spouse/partner, associate + child(ren) or associate + family). Refer to the charts at the beginning of this chapter for a complete listing of the HRA plan deductibles. If you choose coverage for yourself and any dependents, the network deductible and the out-of-network deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

When you receive medical services covered by the Plan, amounts you pay toward meeting the network annual deductible apply toward meeting the out-of-network annual deductible, and vice versa.

**Expenses that don't count toward the annual deductible.** The following expenses are not applied toward either the network or out-of-network annual deductible:

- Pharmacy copayments/coinsurance (including copay assistance from a third party)
- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

#### MEETING THE DEDUCTIBLE: AN EXAMPLE

Associate John Doe is married with one child. He has enrolled for associate + family coverage under the HRA High Plan, which has a $3,500 annual deductible for network expenses. Under this plan, he receives $1,000 in company-provided HRA funds. All three family members have covered network medical expenses. Two are $750 each and one is $2,000, for a total of $3,500. The HRA pays for the first $1,000 of expenses, leaving $2,500 to be paid by John Doe. After he pays the $2,500, his annual deductible is met. For any further network charges during the year, the Plan will pay 75% of covered expenses for network charges and John Doe will be responsible for the remaining 25%.

Or, if only one family member has a covered medical expense of $3,500, the HRA will pay $1,000 of the expense. When John Doe pays the remaining $2,500, the family's annual deductible for network charges is met

### HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE HRA HIGH PLAN AND THE HRA PLAN

For the HRA High Plan and the HRA Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses and you pay 25%. For out-of-network expenses, after you meet the Plan's annual deductible for out-of-network expenses, the Plan pays 50% of the maximum allowable charge (except for emergency care, which is paid at the in-network coinsurance rate of 75%) and you pay the rest — i.e., you are responsible for the other 50% plus any amount charged above the maximum allowable charge.

After you've met the applicable out-of-pocket maximum for eligible network expenses, the Plan then pays 100% of covered network medical expenses for the rest of the calendar year. There is no annual out-of-pocket maximum for charges by non-network providers — you are responsible for paying your share of these charges in full.

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

- Your network and out-of-network annual deductibles (including amounts paid by the HRA)
- Your coinsurance when using network providers, and
- Pharmacy copays/coinsurance.

Your network annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

**Expenses that don't count toward the network annual out-of-pocket maximum.** The following expenses are not applied toward the network annual out-of-pocket maximum:

- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Your coinsurance when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements 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), and
- Charges excluded by the Plan.

If you choose associate-only coverage under either the HRA High Plan or the HRA Plan, you will have an individual out-of-pocket maximum for network expenses of $6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum for network expenses of $13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of $6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

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### HOW THE HSA PLAN ANNUAL DEDUCTIBLES WORK

If you enroll in the HSA Plan and contribute to a Health Savings Account, Walmart matches your payroll deductions into your Health Savings Account, dollar-for-dollar up to $350 if you have individual coverage, or $700 if you have family coverage. Your and Walmart's combined contributions to your Health Savings Account cannot exceed the 2018 annual limit (as determined by the IRS) of $3,450 for individual coverage or $6,900 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

Like the HRA High Plan and the HRA Plan, the HSA Plan includes separate annual deductibles for network and out-of-network charges. These are the amounts you are responsible for spending each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses. See Your provider network later in this chapter for more information on network and non-network providers.

Preventive care services, as described in the Preventive care program section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your deductible depends on whether you are covering just yourself under the HSA Plan (associate only) or any eligible dependents as well (associate + spouse/partner, associate + child(ren) or associate + family). Refer to the chart at the beginning of this chapter for a complete listing of deductibles. If you choose coverage for yourself and any dependents, the network and out-of-network deductibles may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

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

If you enroll in the HSA Plan, you will generally pay full cost for prescriptions until you meet your annual deductible. The exception is medications on Express Scripts' list of approved preventive medications, which are not subject to the HSA Plan's annual deductible — these medications can be purchased at the appropriate copay or coinsurance level, even if you have not met the HSA Plan's network annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See The pharmacy benefit chapter for details. With the exception of these charges for approved preventive medications, your pharmacy charges under the HSA Plan will apply toward your network annual deductible and out-of-pocket maximum.

When you receive medical services covered by the Plan, amounts you pay toward meeting the network annual deductible apply toward meeting the out-of-network annual deductible, and vice versa.

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**Expenses that don't count toward the annual deductible.** The following expenses are not applied toward either the network or out-of-network annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

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

For the HSA Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of covered expenses and you pay 25%. For out-of-network expenses (except for emergency care, as defined by the Third Party Administrator), after you meet the Plan's annual deductible for out-of-network expenses, the Plan pays 50% of the maximum allowable charge and you pay the rest (i.e., you are responsible for the other 50% plus any amount charged above the maximum allowable charge).

After you've met your out-of-pocket maximum for network expenses, the Plan then pays 100% of covered network medical expenses for the rest of the calendar year.

There is no annual out-of-pocket maximum for charges by non-network providers — you are responsible for paying your share of these charges.

### HOW YOUR COVERAGE WORKS UNDER THE HRA HIGH PLAN, THE HRA PLAN AND THE HSA PLAN

| | HRA High Plan and HRA Plan | HSA Plan |
|---|---|---|
| Paying from your account | Covered expenses (except prescriptions) are automatically paid from your HRA, including any rollover balance until it is used up. Any money left in your HRA at the end of the Plan year remains in your account for the next Plan year as long as you continue to enroll in one of the HRA plans. Your HRA balance will never exceed the network deductible for the plan in which you are enrolled. | You can choose to pay your covered medical expenses from your Health Savings Account, or you can pay them out of your own pocket and save your Health Savings Account money. Any unspent money left in your Health Savings Account remains in your account for your future use, and can be taken with you upon termination of your employment. |
| Meeting your annual deductible | After your HRA is used up, you pay covered medical expenses out of your own pocket until your annual deductible is met. | You pay expenses out of your own pocket or from your Health Savings Account until your annual deductible is met. |
| The Plan pays a percentage of covered expenses | After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. After your out-of-network annual deductible is met, the Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge. | After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. After your out-of-network annual deductible is met, the Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge. |
| The Plan pays 100% of covered network services after you meet your out-of-pocket maximum | After you have met your out-of-pocket maximum for the year (as defined by the Plan), the Plan pays 100% of covered network expenses for the rest of the calendar year. (Charges by non-network providers after you have met your out-of- network annual deductible do not apply to your out-of-pocket maximum — you continue to be responsible for paying your share of these charges in full.) | After you have met your out-of-pocket maximum for the year (as defined by the Plan), the Plan pays 100% of covered network expenses for the rest of the calendar year. (Charges by non-network providers after you have met your out-of- network annual deductible do not apply to your out-of-pocket maximum — you continue to be responsible for paying your share of these charges in full.) |

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

- Pharmacy copays/coinsurance
- Your network and out-of-network annual deductibles (including amounts you choose to pay out of your Health Savings Account)
- Your coinsurance when using network providers, and
- Pharmacy charges before your network annual deductible is met.

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

**Expenses that don't count toward the network annual out-of-pocket maximum.** The following expenses are not applied toward the network annual out-of-pocket maximum:

- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Your coinsurance when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- Charges for service provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements 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), and
- Charges excluded by the Plan.

If you choose associate-only coverage under the HSA Plan, you will have an individual out-of-pocket maximum for network expenses of $6,650. If you choose associate + spouse/ partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum for network expenses of $13,300.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of $6,650. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

## The Accountable Care Plan

The Accountable Care Plan options are available to associates who work in designated regions and their eligible dependents. The associate's work location will determine if an Accountable Care Plan option is available to the associate and his or her dependents. See The Accountable Care Plan options earlier in this chapter for a listing of the plans and the areas they serve.

**NOTE:** In areas where associates can select the Accountable Care Plan, they will generally not have access to the HRA High Plan option. The exception is Arkansas, where associates will continue to have access to the HRA High Plan.

The Accountable Care Plan options draw upon the services of "accountable care organizations." These are groups of doctors, clinics, hospitals and other providers who 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.

**IF YOU HAVE COVERAGE UNDER THE PRESBYTERIAN ACCOUNTABLE CARE PLAN**

When you have a covered visit to a doctor's office, your charge will depend on whether your provider participates in the Plan's Tier 1 or Tier 2. Your charge for an office visit to Tier 1 providers (primary care physicians or specialists) will be a copayment, as listed in the Presbyterian Accountable Care Plan summary chart earlier in this chapter. If your provider is a Tier 2 provider, the visit will be subject to the annual deductible and coinsurance.

Tier 1 providers are generally primary care physicians in the Presbyterian Healthcare Services network, Optum Behavioral Health specialists and UnitedHealthcare premium specialists. Tier 2 providers are UnitedHealthcare primary care physicians and specialists. For details on locating providers in either network, visit WalmartOne.com.

An important difference between the Accountable Care Plan and the HRA Plan, the HRA High Plan and the HSA Plan is that under the Accountable Care Plan you must always use the specific doctors, hospitals and other providers that are in the Accountable Care Plan network. If you receive services from a provider outside the Accountable Care Plan network, your expenses will not be covered, except in cases of emergency (as defined by the Third Party Administrator).

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Note, however, that participants enrolled in an Accountable Care Plan option are eligible to participate in the Centers of Excellence programs. If you have dependents who live and seek care outside the network coverage area, their charges will not be covered by the Plan, except in cases of emergency (as defined by the Third Party Administrator).

### HOW THE ACCOUNTABLE CARE PLAN'S ANNUAL DEDUCTIBLE WORKS

Under the Accountable Care Plan, you must meet an annual deductible before certain services are covered under the Plan. Other services such as visits to network doctors are exempt from the deductible, but are subject to a copayment — a fixed fee you must pay each time you use the service. The amount of your deductible is based on whether you are covering just yourself or any eligible dependents as well. Refer to the Accountable Care Plan summary charts at the beginning of this chapter for a listing of the coverage under the Accountable Care Plan options, including deductibles and copayments.

If you choose coverage for yourself and any dependents, the annual deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire deductible has been met.

**Expenses that don't count toward the annual deductible.** The following expenses are not applied toward the annual deductible:

- Medical copayments
- Pharmacy copayments/coinsurance (including copay assistance from a third party)
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services, and
- Non-network providers' charges.

### HOW COINSURANCE, COPAYMENTS AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE ACCOUNTABLE CARE PLAN

For any of the Accountable Care Plan options, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses subject to coinsurance and you pay 25%. (For services subject to a copayment, such as doctor visits, you must continue to pay the copayment until your annual out-of-pocket maximum is met.)

After you've met the out-of-pocket maximum for eligible expenses, the Plan then pays 100% of covered medical expenses for the rest of the calendar year.

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

- Your annual deductible
- Your copayments and coinsurance charges, and
- Pharmacy copays/coinsurance.

Your out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

**Expenses that don't count toward the annual out-of-pocket maximum.** The following expenses are not applied toward the annual network out-of-pocket maximum:

- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements 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)
- Non-network providers' charges, and
- Charges excluded by the Plan

If you choose associate-only coverage under the Accountable Care Plan, you will have an individual out-of-pocket maximum of $6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of $6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

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## The Select Network Plan

Associates who work in designated regions will have access to the Select Network Plan, administered by Aetna. In each of the areas where the Select Network Plan is available, associates will not have access to the HRA High Plan option.

As in the Accountable Care Plan, Select Network Plan participants must always use the specific doctors, hospitals and other providers that are in the Select Network Plan's network. With the exception of emergency services (as defined by the Third Party Administrator), coverage is provided only for care received from providers in the Plan's network. Note, however, that participants enrolled in the Select Network Plan are eligible to participate in the Centers of Excellence program. If you have dependents who live or seek care outside the network coverage area, their charges will not be covered by the Plan, except in cases of emergency (as defined by the Third Party Administrator).

### HOW THE SELECT NETWORK PLAN'S ANNUAL DEDUCTIBLE WORKS

The Select Network Plan includes an annual deductible you must meet each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses.

The amount of your deductible is based on whether you are covering just yourself or any eligible dependents as well. Refer to the chart at the beginning of this chapter for a listing of the coverage under the Select Network Plan, including deductibles.

If you choose coverage for yourself and any dependents, the deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

**Expenses that don't count toward the annual deductible.** The following expenses are not applied toward the annual deductible:

- Medical copayments
- Pharmacy copayments/coinsurance (including copay assistance from a third party)
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services, and
- Non-network providers' charges.

### HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE SELECT NETWORK PLAN

Under the Select Network Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses and you pay 25%.

After you've met the out-of-pocket maximum for eligible expenses, the Plan then pays 100% of covered medical expenses for the rest of the calendar year.

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

- Your annual deductible
- Your copayments and coinsurance charges, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

**Expenses that don't count toward the annual out-of-pocket maximum.** The following expenses are not applied toward the annual network out-of-pocket maximum:

- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements 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)
- Non-network providers' charges, and
- Charges excluded by the Plan.

If you choose associate-only coverage under the Select Network Plan, you will have an individual out-of-pocket maximum of $6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of $6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family

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out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

## What is covered by the Associates' Medical Plan

The Associates' Medical Plan pays benefits for covered expenses, which are charges for procedures, services, equipment and supplies that are defined under the Plan as:

- Not in excess of the maximum allowable charge, which is determined by the Third Party Administrator (TPA), as described below
- Medically necessary (as defined below)
- Not excluded under the Plan — see What is not covered by the Associates' Medical Plan later in this chapter, and
- Not in excess of Plan limits.

### MAXIMUM ALLOWABLE CHARGE

The "maximum allowable charge" (MAC) 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. The MAC applies to both in-network services and out-of-network services.

For covered in-network services, the MAC is that portion of a provider's charge covered by the Plan, as determined by the provider's contract with the Third Party Administrator (TPA). In the case of BlueAdvantage Administrators of Arkansas, this includes contracts with an independent licensee company of the Blue Cross and Blue Shield Association; in the case of UnitedHealthcare, this includes Medica and Harvard Pilgrim Health Care, independent licensees of UnitedHealthcare. For information about the TPA for your medical plan coverage, see Your provider network later in this chapter.

For covered out-of-network services, the MAC is determined by each TPA, as described below. In certain circumstances, network benefits may be paid for out-of-network services, as described later in this section under When network benefits are paid for out-of-network expenses.

**Aetna:** The MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For involuntary out-of-network service, the MAC also is 125% of Medicare's maximum allowable charge unless the provider is in Aetna's National Advantage Program (NAP). NAP provider charges are paid at a discount. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, Aetna uses a gap methodology to calculate the MAC that is based on the Medicare maximum allowable charge. Medicare's allowable rate is based upon the geographic area in which the service is furnished.

**UnitedHealthcare:** The MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For involuntary out-of-network services, the MAC also is 125% of Medicare's maximum allowable charge unless the provider is in UnitedHealthcare's Shared Savings Program (SSP). SSP provider charges are paid at a discount. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, UnitedHealthcare uses a gap methodology to calculate the MAC.

**HealthSCOPE Benefits:** There is no benefit for out-of-network services sought voluntarily by participants in Accountable Care Plans administered by HealthSCOPE Benefits. For approved involuntary or emergency out-of-network services, HealthSCOPE Benefits will use a discount through a "wrap network," if available and consistent with the Affordable Care Act. (A wrap network is a group of non-contracted providers who have arranged to provide services to Plan participants at a discount.) If there is not a discount available through a wrap network, the MAC will be 125% of Medicare's maximum allowable charge. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, HealthSCOPE Benefits will use a gap methodology to calculate the MAC. There may be some circumstances in which a single-case agreement is reached with the out-of-network provider.

**BlueAdvantage Administrators of Arkansas:** The method for establishing the MAC for covered out-of-network services varies, depending on whether the service was delivered by an individual health care provider (e.g., a physician), by an ambulance or air ambulance service, or by an inpatient or outpatient hospital or facility. For services of individual health care providers, and for ambulance and air ambulance transport, the MAC is 125% of the amount that the federal Medicare program allows for such services on the date administered. For hospital and facility services, or for any other covered benefits (e.g., drugs, medical devices, products or implants, equipment or supplies), the Plan's MAC for covered out-of-network services is limited to the allowance set by BlueAdvantage Administrators of Arkansas in its discretion, utilizing such methods or benchmarks as BlueAdvantage Administrators of Arkansas may choose to employ; or, if BlueAdvantage Administrators of Arkansas does not have its own method or benchmark in a given case, then the Plan's MAC for covered out-of-network services is limited to the pricing or allowance offered by the Blue Cross and Blue Shield Plan in the state where services were provided (known as the "Host Plan").

For covered out-of-network services, the Plan will pay the lesser of MAC or the provider's actual billed charges. If the provider's billed charges exceed the Plan's MAC, you are responsible for paying your provider the difference. For additional information, call your health care advisor at the number on your plan ID card.

**MEDICALLY NECESSARY**

"Medically necessary" generally means the Plan has determined the procedure, service, equipment or supply to be:

- Appropriate for the symptoms, diagnosis or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not primarily for the convenience of the patient or the patient's doctor or other provider, and
- The most appropriate (as defined below) procedure, service, equipment or supply that can be safely provided.

"Most appropriate" means:

- There is valid scientific evidence (e.g., through MCG, formerly Milliman Care Guidelines) demonstrating that the expected health benefits from the procedure, service, equipment or supply are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications, for the Plan participant with the particular medical condition being treated than other possible alternatives
- Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable, and
- For hospital stays, acute care as an inpatient is necessary due to the kind of services the Plan participant is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Aetna, UnitedHealthcare, BlueAdvantage Administrators of Arkansas, HealthSCOPE Benefits and Mercy Health Springfield Communities (with respect to all the Mercy Accountable Care Plans) follow policies and procedures in determining whether a procedure, service, equipment or supply is medically necessary. Your Plan benefits are subject to the terms of these policies, which may vary by Third Party Administrator.

You and your health care provider can access the coverage policies of Aetna, UnitedHealthcare and BlueAdvantage Administrators of Arkansas at their respective websites, listed in the **Associates' Medical Plan Resources** chart at the beginning of this chapter. Access the coverage policies of HealthSCOPE Benefits by calling **800-804-1272**.

For all TPAs, your Plan benefits are subject to all terms, conditions, limitations and exclusions set forth in the Plan-specific coverage policies administered by the TPAs regarding medical necessity.

## Your provider network

Depending on each covered associate's work location and choice of medical plan, participants in the Associates' Medical Plan have their benefits administered by one of the following Third Party Administrators:

- BlueAdvantage Administrators of Arkansas
- Aetna
- UnitedHealthcare, or
- HealthSCOPE Benefits.

The Plan has contracted with each of the above Third Party Administrators and also with Mercy Health Springfield Communities (for all Mercy Accountable Care Plans), Emory and UnityPoint to provide a network of health care providers (for example, doctors and hospitals) from whom participants can receive medical services and supplies covered under the Associates' Medical Plan at discounted prices. Network providers accept an amount negotiated by the Third Party Administrator for covered expenses as payment in full (this is the maximum allowable charge for in-network services), subject to the annual deductible and cost-sharing terms applicable to the coverage you have chosen.

**If you are covered under the HRA High Plan, the HRA Plan or the HSA Plan:** When you see a network provider, the Plan will pay 75% of covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of the covered expenses. (Network providers do not charge more than the maximum allowable charge amount for covered expenses.)

When you see a non-network provider, the Plan will pay 50% of the maximum allowable charge after you have met the applicable annual deductible; you are responsible for paying all remaining amounts (i.e., your 50% share of the maximum allowable charge plus any amount above the maximum allowable charge).

**If you are covered under the Accountable Care Plan:** When you see a network provider, the Plan will pay 75% of certain covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of covered expenses. For services not subject to the annual deductible — e.g., doctor visits — you are responsible for paying the applicable copayment. (Note, however, that certain doctor visits under the Presbyterian Accountable Care Plan are subject to deductible and coinsurance, as described earlier under **If you have coverage under the Presbyterian Accountable Care Plan.**)

When you see a non-network provider, the Plan pays no benefits except in cases of emergency, as defined by the Third Party Administrator.



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**If you are covered under the Select Network Plan:** When you see a network provider, the Plan will pay 75% of covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of the covered expenses. (Network providers do not charge more than the maximum allowable charge amount for covered expenses.)

When you see a non-network provider, the Plan pays no benefits except in cases of emergency, as defined by the Third Party Administrator.

**In all plan options available under the Associates' Medical Plan:** Eligible preventive care is paid at 100%. In addition, eligible expenses are paid at 100% when you have reached applicable out-of-pocket maximums.

Online provider directories are available on WalmartOne.com or the WIRE.

If your provider leaves the network, your benefit will be adjusted accordingly, based on the terms of your Plan. If you are covered under the HRA High Plan, the HRA Plan or the HSA Plan, services provided by a provider who has left the network will generally be treated as an out-of-network benefit; you may be required to pay any amount over what the Plan allows for covered expenses (that is, amounts above the maximum allowable charge), unless you choose another provider who is in the network. If you are covered under an Accountable Care Plan or the Select Network Plan, which provide no coverage for non-network providers except in cases of emergency, as defined by the Third Party Administrator, your provider's services will not be covered under the Plan.

The Plan does not furnish hospital or medical services and is not liable for any act or omission of any provider or agent of such provider, including failure or refusal to render services. All medical decisions are between you and your provider. The Plan makes no representations regarding the quality of care or services rendered by any provider.

**NOTE:** As part of their contracts with some network providers, the Third Party Administrators or the Plan and the providers have agreed to certain financial incentive arrangements (which may pay bonuses or withhold payments to the providers) that are designed to reward high-quality and cost-effective treatments in connection with certain services. All of the Accountable Care Plan contracts include such arrangements. You may contact your Third Party Administrator for more information regarding these arrangements.

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

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

- If your dependent child(ren) under age 19 requires treatment at a Children's Miracle Network hospital
- When there are no network providers with the relevant specialty within 30 miles of the participant's home. (This does not apply to the Accountable Care Plan options)
- Services from a non-network provider involving a pregnant participant will be treated as network charges for up to six weeks after delivery if she began receiving care from the provider when the provider was a network provider and there had not been an interruption of the doctor/patient relationship
- Services from a non-network provider, until the effective date of the next annual enrollment period, for a course of treatment that began when the provider was a network provider, where there has not been an interruption of the doctor/patient relationship (for example, if you change Third Party Administrators during the year because of a change in work location and are in the middle of a course of treatment)
- Services for laboratory, anesthesia, radiology or pathology, but only if such services are received in connection with care from a network provider or from a network hospital
- Services for treatment received while on vacation or business travel in the U.S., where such treatment either could not have reasonably been foreseen prior to the travel or the course of treatment began prior to the travel and for medical reasons must be continued during such travel, or
- Until the next annual enrollment period, when coverage under the Plan is added and utilizing a non-network provider in a course of treatment begun prior to effective date, where there has not been an interruption of the doctor/patient relationship.

**NOTE:** The Plan will cover emergency care services provided in an emergency room of a hospital at a network coinsurance rate of 75% without any prior authorization and without regard to whether the services are provided in a network facility or by a network provider. Emergency care is defined by the Third Party Administrator according to Affordable Care Act guidelines.

If your Third Party Administrator determines that any of the above circumstances apply, services will be covered at the network coinsurance rate of 75%. Keep in mind that since the provider is not in the network, you may have to pay for treatment when you receive it and file a claim for reimbursement, which will be based on the maximum allowable charge. This means that the provider may bill you for the difference between the maximum allowable charge paid by the Plan and the provider's actual charge.

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In addition, in each of the situations listed below, your out-of-network covered expenses may be treated as network covered expenses. The amounts paid by the Plan for the following will be based on up to 200% of the maximum allowable charge:

- Transport by ambulance or air ambulance
- The participant is directly admitted to the hospital from an emergency room, or
- The participant dies prior to hospital admission.

Amounts in excess of 200% of the maximum allowable charge will be your responsibility and will not count toward your annual deductible or out-of-pocket maximum. Maximum allowable charge exceptions will not be granted in circumstances other than those described in this section. For additional information about air ambulance coverage, call your health care advisor at the number on your plan ID card.

**COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY**

If you travel abroad, follow these steps:

- Before you begin your travel, contact your Third Party Administrator (or your HMO) for details about medical coverage and emergency medical services when traveling abroad. Coverage outside the United States may vary.
- Always carry your plan ID card with you when you travel, and present it when you receive medical services.

## Special provider networks

In some locations, participants in the Associates' Medical Plan will have access to special provider networks that have coverage provisions differing in certain ways from the Plan provisions detailed on the preceding pages. General information about these special networks follows.

### ALTERNATE NETWORKS THROUGH BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS

Associates in certain locations nationwide who have BlueAdvantage Administrators of Arkansas as their Third Party Administrator will have access to alternate networks of providers. An alternate network is essentially a network within a network, a subgroup of providers within the Plan's larger network in a particular service area. In locations in which an alternate network operates, associates will need to see the alternate network providers in order to receive network terms under the Plan — i.e., network annual deductibles and network-level coinsurance.

If associates seek services from medical providers who are within the area served by the alternate network but who have not agreed to be providers within the alternate network, those services will be treated as out-of-network and covered accordingly.

The alternate networks through BlueAdvantage Administrators of Arkansas are as follows:

- Florida: NetworkBLUE
- Georgia: Blue Open Access POS
- Kansas City, Missouri: Preferred-Care Blue
- Maryland, Northern Virginia, District of Columbia: BlueChoice Advantage Open Access
- Missouri: Blue Preferred POS
- New Hampshire: BlueChoice Open Access POS
- New Jersey: Horizon Managed Care Network
- Pennsylvania: Community Blue Network.
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

For additional information about the alternate networks listed above, including details about service areas, go to the WIRE or WalmartOne.com or call your health care advisor at the number on your plan ID card.

### ADDITIONAL NETWORKS THROUGH UNITEDHEALTHCARE

**Medica Choice Network.** Associates who have UnitedHealthcare as their Third Party Administrator and who live in the following locations will have access to the Medica Choice Network:

- Minnesota
- North Dakota
- South Dakota
- Wisconsin, in the following counties only: Polk, Pierce, St. Croix, Burnett, Douglas, Bayfield-Ashland, Washburn, Sawyer, Barron, Dunn, Chippewa and Eau Claire.

**HPHC Insurance Company.** Associates who have UnitedHealthcare as their Third Party Administrator and who live in the following locations will have access to HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care:

- Massachusetts
- Maine
- New Hampshire.

## Preventive care program

Associates enrolled in the Associates' Medical Plan will have 100% coverage for the cost of eligible preventive care services when network providers are used. If an



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associate enrolled in the HRA High Plan, the HRA Plan or the HSA Plan uses a non-network provider for eligible preventive care services, the Plan will reduce the benefit to 50%, and coinsurance amounts will not apply toward your out-of-pocket maximum. (If an associate enrolled in one of the Accountable Care Plan options or the Select Network Plan uses a non-network provider for preventive care services, no benefits will be provided, and any out-of-pocket costs will not count toward your out-of-pocket maximum).

In order for a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of the government agencies responsible for development of U.S. preventive care guidelines, as required under the Affordable Care Act. Many of the guidelines are specific to gender, age or your personal risk factors for a disease or condition.

Please check with your Third Party Administrator for additional details and for answers to questions regarding available preventive care services.

Covered services include those listed below. For the most up-to-date list of covered preventive services, go to the WiRE or WalmartOne.com or call your Third Party Administrator at the number on your plan ID card. Refer to your Third Party Administrator for information about coverage terms when you receive preventive care services in addition to services listed here.

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### COVERED PREVENTIVE SERVICES FOR ADULTS

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol misuse** screening and counseling
- **Aspirin** use for men and women of certain ages (prescription required). Please see The pharmacy benefit for more information.
- **Blood pressure** screening for all adults
- **Cholesterol screening** for adults of certain ages or at higher risk
- **Colorectal cancer** screening for adults over 50
- **Depression** screening for adults
- **Diabetes (type 2)** screening for adults with high blood pressure, adults age 40–70 who are overweight or obese, and counseling for patients with abnormal blood glucose
- **Diet and physical activity** counseling for adults at higher risk for chronic disease
- **Exercise or physical therapy** for community-dwelling adults age 65 and older who are at increased risk for falls
- **Hepatitis B** screening for adults at high risk
- **Hepatitis C** screening for adults at high risk
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults — doses, recommended ages and recommended populations vary:
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, diphtheria, pertussis
  - Varicella

Learn more about immunizations and see the latest vaccine schedules at: cdc.gov/vaccines/schedules.

- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 55–80 who have a smoking history
- **Obesity** screening and counseling for all adults
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Syphilis** screening for all adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users
- **Vitamin D** for participants age 65 and older (prescription required)

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### COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

- **Aspirin (low dose)** for women 12 weeks pregnant who are at high risk for preeclampsia (prescription required). Please see The pharmacy benefit for more information.
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk; and, if indicated after counseling, BRCA testing
- **Breast cancer chemoprevention** counseling for women at higher risk
- **Breast cancer mammography** screenings every 1–2 years for women over 40
- **Breast cancer risk-reducing prescription medications** (such as Tamoxifen or Raloxifene) for certain women at increased risk for breast cancer
- **Breastfeeding** comprehensive support and three counseling visits from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Please check with your Third Party Administrator for details on how to obtain a breast pump.
- **Cervical cancer** screening for women age 21–65
- **Chlamydia infection** screening for younger women and other women at higher risk

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- **Contraception** Food and Drug Administration–approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs. Please see The pharmacy benefit for information about contraception.
- **Domestic and interpersonal violence** screening and counseling for all women and, when needed, initial intervention services
- **Folic acid** supplements for women who may become pregnant (prescription required). Please see The pharmacy benefit for more information.
- **Gestational diabetes** screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for younger women and other women at increased risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human immunodeficiency virus (HIV)** screening and counseling
- **Osteoporosis** screening for women over age 65, and younger women depending on risk factors
- **Rh incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Sexually transmitted infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Well-woman visits** to obtain recommended preventive services for women

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## COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Anemia** screening for children at 12 months
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Bilirubin** screening for newborns
- **Blood pressure** screening for children of all ages
- **Blood** screening for newborns
- **Cervical dysplasia** screening for sexually active females
- **Congenital hypothyroidism** screening for newborns
- **Critical congenital heart defect screening** for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride chemoprevention** supplements for children without fluoride in their water source and fluoride varnish to the primary teeth of all infants and children (prescription required)
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all children
- **Height, weight, length, head circumference, weight for length and body mass index** measurements for children
- **Hematocrit or hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **Hepatitis B** screening in adolescents at high risk
- **HIV** screening for adolescents
- **Immunization** vaccines for children from birth to age 18 — doses, recommended ages and recommended populations vary:
  - Diphtheria, tetanus, pertussis (DTaP and Dtap)
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella

Learn more about immunizations and see the latest vaccine schedules at cdc.gov/vaccines/schedules.

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- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** screening and counseling
- **Oral health** risk assessment for young children, newborn to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Physical examination** for children of all ages
- **Sexually transmitted infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Tobacco use** interventions in school-aged children and adolescents
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children.

## FLU VACCINE PROGRAM

Walmart provides an annual flu vaccination, covered at 100%, during the September–March flu season. Details of the program include:

- Vaccinations may be provided in participating Walmart and Sam's Club pharmacies.



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- Associates' Medical Plan participants must show their plan ID card to receive the covered flu vaccine.
- Associates enrolled in the Associates' Medical Plan can go to any network provider and receive the flu vaccine, covered at 100%, through the preventive care program. If you are enrolled in the HRA High, HRA or HSA Plan and go to a provider who is not in the network, the benefit is 50% of the maximum allowable charge, and you will be responsible for the other 50% plus any amount above the maximum allowable charge. If you are enrolled in one of the Accountable Care Plan options or the Select Network Plan, you must go to a network provider to be eligible for the benefit.

**BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM**

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

Under the HRA High Plan, HRA Plan and HSA Plan, covered network services are paid at 75% after you've met your annual deductible. Covered network services are also paid at 75% after you've met your annual deductible for participants in the Presbyterian Accountable Care Plan who see providers in Presbyterian Tier 1. Under all other plan options, behavioral health office visits are charged at a $35 copay for each visit.

For participants in the HRA High Plan, the HRA Plan and the HSA Plan, if you use a non-network provider, covered services are paid at 50% of the maximum allowable charge after you've met your annual deductible. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. Coinsurance for out-of-network services does not apply to your out-of-pocket maximum.

For participants in the Accountable Care Plan and the Select Network Plan, services from non-network providers are not covered except in cases of emergency, as defined by the Third Party Administrator.

Coverage is provided for:

- 24-hour inpatient care
- Residential treatment facility
- Partial hospitalization or outpatient care that requires six to eight hours of service per day, five to seven days per week, or
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week.

## Prenotification

Where your TPA does not otherwise require prior authorization of a service (see Preauthorization below), you or your provider may voluntarily contact your Third Party Administrator for information regarding coverage prior to your obtaining most medical and behavioral health services by calling the number on your plan ID card. If you or your provider chooses to notify your Third Party Administrator of a scheduled medical or behavioral health admission, you should do so at least 24 hours prior to the scheduled admission. For all emergency medical and behavioral health services, Third Party Administrators should be notified as soon as possible, but no later than 24 hours after admission. Providing notification within 24 hours after admission is not, however, required as a condition of coverage.

The Third Party Administrator's responses to your inquiries in a prior-notification call do not guarantee payment or ensure coverage under the Associates' Medical Plan, nor do any statements made by the Third Party Administrator in telephone calls, conversations or emails waive any term or condition of the Plan that applies to your claim for Plan benefits. While the Third Party Administrator will work to answer your questions regarding coverage, the Third Party Administrator cannot make a final claim determination on the telephone or by email. This means that any responses given by telephone or email will always be subject to further review under the written terms, conditions, limitations and exclusions of the Plan.

Your coverage may be limited or denied if, when the claims for the services are received, review shows that a benefit exclusion or limitation applies, the covered participant ceased to be eligible for benefits on the date services were provided, coverage lapsed for nonpayment of premiums, out-of-network limitations apply, or any other basis exists for denial of the claim under the terms of the Plan.

## Preauthorization

Under the terms of the Associates' Medical Plan, network providers are required to obtain prior authorization of certain services. The types of services subject to prior authorization include, but are not limited to:

- Inpatient admissions (to hospital, hospice and other facilities) for medical benefits, including residential treatment facilities
- Inpatient admissions (to behavioral health facilities) for mental health and substance abuse benefits
- Maternity inpatient stays that exceed the Third Party Administrator's standard length of stay
- Home health care
- Outpatient surgery, radiology services, dialysis

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- Outpatient services for mental health and substance abuse, including:
  - Detoxification
  - Electroconvulsive therapy (ECT)
  - Applied behavior analysis (ABA)
  - Biofeedback
  - Neuropsychological testing
  - Partial hospitalization day treatment
  - Intensive outpatient treatment
  - Psychiatric home care
- Non-emergency ambulance (air or ground)
- Reconstructive procedures that may be considered cosmetic
- BRCA genetic testing
- Rehabilitation services (physical therapy, occupational therapy, speech therapy)
- Certain prosthetic devices and durable medical equipment
- Clinical trials
- Specialty drugs issued by provider
- Services provided under the Centers of Excellence program, including:
  - Heart surgery
  - Breast, lung and colorectal cancer medical record review
  - Spine surgery
  - Hip and knee replacement
  - Transplants (including organ, stem cell and bone marrow)
  - Ventricular assist devices (VADs) and total artificial hearts
  - Weight loss surgery

Please note that the prior authorization requirements may vary based on Third Party Administrator. For a complete list of services for which preauthorization is required, please call your health care advisor at the phone number listed on your plan ID card.

Your network provider will seek preauthorization of these services on your behalf. For non-network services, you may need to seek preauthorization yourself. If your preauthorization request is approved, that means the requested services will be treated as covered services under the Plan as long as you are otherwise eligible to receive Plan benefits.

If your preauthorization request is denied, you and your provider will be notified, and either you or your provider may appeal the denial, although your provider is not required to do so. If you decide to proceed with a service that is not preauthorized, you may be responsible for paying all of your provider's charges. For more information on how to appeal a denied request for preauthorization, see the **Claims and appeals** chapter.

## Helping you manage your health

When you need to communicate with your Third Party Administrator for any reason — whether to locate providers, seek preapproval for a planned service, speak to a registered nurse, inquire about a claim or for another matter — you should call the number on your plan ID card. This will be your health care advisor, your single point of contact for all inquiries and communication with your Third Party Administrator. Depending on the nature of your issue, the health care advisor will answer your question or route you to the appropriate department. (In some locations, a health care advisor may also be available at your work location to provide similar services.) This process will help ensure that all covered associates and their dependents can receive consistent information and guidance for all coverage-related inquiries.

### CARE MANAGEMENT

All associates and dependents who are enrolled in one of the plans offered by the Associates' Medical Plan will have the benefit of voluntary care management services, including your own personal nurse care manager. These services are intended to bring consistency to the full range of care and services provided to Plan participants. Successful care management aims to look at the whole individual rather than just the symptoms or conditions being diagnosed; it can result in higher quality of care, an improvement in your experience with your providers and Third Party Administrator, as well as potentially lower out-of-pocket medical expenses overall.

When appropriate, a specially trained and registered nurse care manager will help you, the associate, as well as your covered dependents. Circumstances in which a nurse care manager will work with you might include any of the following:

- You are sick or injured and hospitalized
- You are scheduled for surgery
- You find out you have a chronic illness or are dealing with an ongoing chronic illness
- You have a behavioral health/substance abuse condition
- You are prescribed multiple prescription drugs with potential interactions
- You simply have a question about your health
- You are home from the hospital and need help understanding your discharge plan, or
- You are participating in the Life with Baby Maternity Program, or the comparable maternity program offered by certain Accountable Care Plans.

Under the care management program provided by your Third Party Administrator, your nurse care manager, in collaboration with your medical provider, has the authority to approve services that are not otherwise covered by the Plan because they exceed a treatment limit (i.e., number of days or visits), or maternity-related services, but only if the

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otherwise excluded services are deemed to be medically necessary. The Plan's general rules regarding annual deductibles and coinsurance will continue to apply to any additional benefits authorized by your nurse care manager.

In addition, your nurse care manager will follow your Third Party Administrator's applicable policies and procedures for determining medical necessity in making its decisions.

Your nurse care manager may also be able to assist you with your medical costs incurred for "involuntary" out-of-network services. "Involuntary" means that you could not control your choice of provider (for example, if you had surgery in an in-network hospital, but your anesthesia was administered by an anesthesiologist who was a non-network provider) or had no reasonable basis for believing that your provider was a non-network provider. In some cases, out-of-network benefits may be paid as network benefits (see When Network Benefits Are Paid For Out-Of-Network Expenses earlier in this chapter). In other cases, your Third Party Administrator may negotiate with non-network providers either before or after services are rendered to reduce the billed charges that you are responsible for paying under the Plan's out-of-network benefit in exchange for a larger payment by the Plan (i.e., a payment higher than the otherwise applicable maximum allowable charge). There are no guarantees that care managers will obtain any reduction in the out-of-network costs you are responsible for.

When you communicate with your Third Party Administrator, depending on the nature of your inquiry, you may be routed to your nurse care manager for assistance. On other occasions, your nurse care manager may reach out to you, for example to invite you to participate in a health management program that may be appropriate for you.

When you receive a call from your nurse care manager, please take the call or return it at your earliest convenience so that your nurse care manager can begin to help you. To reach your nurse care manager, call the phone number on your plan ID card. Participation in the program is voluntary and does not affect your eligibility to participate in the Associates' Medical Plan.

### QUIT TOBACCO PROGRAM

Tobacco use is a leading cause of preventable disease and death in the United States, and using tobacco dramatically increases the risk of heart disease and many types of cancer. To help you kick the habit, Walmart offers a free Quit Tobacco program for associates and their covered dependents age 18 and older who are enrolled in a Walmart-sponsored medical plan. The program uses treatment methods to give you personal support and help you quit for good.

When you enroll in the program, a variety of services may be available to you, including:

- **Online support** from coaches and other quitters.
- **Phone-based coaching** with a trained health coach.
- **Quit Guide** handbook, available online or mailed to your home.
- **Email support** with tips to help you quit, stay motivated and celebrate quit milestones.
- **Over-the-counter (OTC) quit medications,** including free patches, gum, lozenges or mini-lozenges. (You may hear this referred to as "nicotine replacement therapy" or "NRT.")

To enroll in a Quit Tobacco program, associates can call 866-577-7169.

If you are enrolled in an HMO, contact your provider to learn what quit-tobacco programs are offered through your plan at no cost to you.

All Walmart associates can learn more about the Quit Tobacco program at the Quit Tobacco link at WalmartOne.com.

### LIFE WITH BABY MATERNITY PROGRAM

Life with Baby is an exclusive prenatal care program offered at no cost to you, your spouse/partner and dependents covered under the Plan. The program is available to all associates enrolled in the Associates' Medical Plan, with the exception of some Accountable Care Plans, which provide a comparable maternity program for their participants. (Call your health care advisor at the phone number on your plan ID card for more information.)

Whether you're starting a family, adding to one or just thinking about it, Life with Baby can help you have a safe, successful pregnancy. The program is offered at no cost, but note that enrollment is not automatic. The program assists with preconception, pregnancy, delivery (including three lactation visits) and child development. Enroll in Life with Baby by calling your health care advisor at the phone number on your plan ID card. Once enrolled, you'll have the opportunity to talk confidentially with a personal registered nurse before, during and after your pregnancy. Participation in the program is voluntary and does not affect your eligibility to participate in the Associates' Medical Plan.

### CASTLIGHT

Castlight is a personalized tool that lets you search for doctors and medical services online and make decisions based on cost information and user reviews. Walmart associates and adult dependents (age 18 and over) who are enrolled in one of the plans offered by the Associates' Medical Plan are eligible to use Castlight with the exception of participants in the Mercy Accountable Care Plans, Emory Accountable Care Plan, Presbyterian Accountable Care Plan and UnityPoint Accountable Care Plan.

As a new user, start using Castlight by registering at MyCastlight.com/Walmart, by mobile app or by calling a health care advisor at the number on your plan ID card. Registered users can return to the application at any time to access Castlight. There is no cost to you when you use Castlight.

With Castlight you can:

- Compare nearby doctors, medical facilities and health care services based on the price you'll pay
- See personalized cost estimates based on your location and your health plan
- Review your Plan details, including your progress toward meeting your deductible and out-of-pocket maximum
- Review explanations of past medical spending so you know how much you paid and why
- Receive recommendations about ways to save money and find quality care
- Access useful information about prescription drugs

**NOTE:** If you are enrolled in one of the Accountable Care Plan options, contact your health care advisor at the number on your plan ID card to obtain information on network doctors and Plan details, and to obtain explanations on past medical spending. You can also find information on network providers on WalmartOne.com.

### SECOND OPINIONS AND SPECIALIST SEARCH THROUGH GRAND ROUNDS

Under certain circumstances, when you have received a diagnosis or been recommended for surgery or a certain treatment, the Plan will cover second opinions provided online through Grand Rounds, a medical technology company. Grand Rounds helps you find high-quality specialists and can match you with specialists to help you get the best possible diagnosis or treatment plan. When you use this service, you can get a written opinion from a qualified physician based on your medical records or an in-person visit, plus recommendations for your care.

Grand Rounds is available to associates covered under the Associates' Medical Plan and their covered dependents, with the exception of associates covered under any of the Accountable Care Plan options. For more information about services and technical requirements, visit Grand Rounds online at GrandRounds.com/Walmart or call 800-941-1384. You can also download the app from the Apple App Store or Google Play.

### TELEHEALTH VIDEO VISITS THROUGH DOCTOR ON DEMAND

Under certain circumstances, the Plan will cover doctor consultations using telecommunication technologies such as video visits. Participants enrolled in the Associates' Medical Plan have access to Doctor On Demand, a telehealth service offering video medical visits. Doctor On Demand's contracted providers can diagnose, treat and write prescriptions for a wide range of non-emergency medical or behavioral health issues. The service is available in all 50 states, 24 hours a day, seven days a week by computer, tablet or smartphone. Doctor On Demand cannot provide treatment for chronic conditions like diabetes, or medical emergencies like chest pain or severe burns.

Doctor On Demand will submit claims for services directly to covered participants' Third Party Administrators. Services provided through Doctor On Demand are subject to the same coverage terms as conventional doctor visits (deductible, coinsurance, etc.). For more information about services and technical requirements, visit Doctor On Demand online at doctorondemand.com or call 800-997-6196.

## Walmart Care Clinic

The Walmart Care Clinic is a primary health care clinic that can be found in select Walmart stores. It offers retail primary care services including office visits, laboratory tests and some preventive care services, for persons age two and older.

Office visits are offered at the discounted price of a $4 copayment per visit for participants in the HRA plans, the Select Network Plan or the Accountable Care Plan options, regardless of residency or work location. Due to IRS rules governing health plans that are used with Health Savings Accounts, associates enrolled in the HSA Plan option are required to pay the posted retail price when using the Walmart Care Clinic, unless the clinic visit is limited to preventive services. HSA dollars may be used as payment for qualified medical expenses received at the clinic.

Lab tests and immunizations that are not covered as preventive care under the Plan but are performed entirely within the clinic setting are available at a separate charge in addition to the visit charge. Tests ordered within the Walmart Care Clinic but performed outside the clinic setting are treated as covered network charges under the Associates' Medical Plan. These charges are subject to the maximum allowable charge paid by the Plan and you would be responsible for any difference between the Plan's maximum allowable charge and the provider's actual charge.

Certain preventive services available at the Walmart Care Clinic are covered under all of the Associates' Medical Plan options. These preventive services are covered at no cost to enrolled associates and their dependents. (See the Preventive care program section earlier in this chapter for a list of services covered at 100% for associates enrolled for medical coverage under the Associates' Medical Plan. For more information, please visit WalmartCareClinic.com.)

### NETWORK COVERAGE FOR CERTAIN WALMART CARE CLINICS

Your Third Party Administrator may contract with certain individual Walmart Care Clinics to be network providers under the Plan, but not all Walmart Care Clinics are network providers. The manner in which the Plan will treat your out-of-pocket expenses at a Walmart Care Clinic depends on the clinic's network status, as follows:

**If the Walmart Care Clinic is a network provider under your Plan option.** The clinic will file insurance claims with your Third Party Administrator. Any eligible out-of-pocket costs you



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incur in that clinic (after your $4 visit copay) will be subject to your annual deductible and out-of-pocket maximum under the same rules that apply to a network provider.

**If the Walmart Care Clinic is not a network provider under your Plan option.** The clinic will not file insurance claims with your Third Party Administrator. Any out-of-pocket costs you incur are not reimbursable under the Plan and will not be credited against your annual deductible or out-of-pocket maximum.

As stated, eligible preventive care services are fully covered regardless of the Walmart Care Clinic's network status. To find out whether a Walmart Care Clinic is a network provider, view your network provider directory or contact your Third Party Administrator.

## Centers of Excellence

The Centers of Excellence program works with specific facilities to provide medical services related to a range of treatments and procedures. Through this program, associates and dependents enrolled in the Associates' Medical Plan have access to highly specialized providers and facilities selected for their demonstrated expertise in certain high-risk or high-cost procedures. This important program is offered by the Associates' Medical Plan so that participants facing certain serious medical conditions can receive high-quality care. The Centers of Excellence program covers:

- Surgeries for certain heart conditions (age 18 and up)
- Surgeries for certain spine conditions (age limitations apply to some spine conditions)
- Hip replacement surgery (age 18 and up)
- Knee replacement surgery (age 18 and up)
- Medical record review by a Centers of Excellence facility for certain types of cancer (all ages) to determine if an on-site evaluation would be recommended
- Organ and tissue transplants (except kidney, cornea and intestinal), including ventricular assist devices (VADs) and total artificial hearts, and
- Gastric bypass and gastric sleeve weight loss surgeries.

The section that follows describes the program in greater detail, including important conditions and restrictions. The Centers of Excellence chart below summarizes general terms for the specific medical services covered under the program. See also the **Transplant** and **Weight loss surgery** sections later in this chapter for details about those benefits.

As shown in the Centers of Excellence summary chart below, certain eligible services performed at one of the medical centers included in the program are covered at 100% with no annual deductible (excluding weight loss surgery). However, if you are enrolled in the HSA Plan, you must meet your annual deductible before the Plan will make any payments, due to federal tax laws.

If you believe you may be a candidate to participate in the Centers of Excellence program, call your health care advisor at the phone number on your plan ID card. To participate in the Centers of Excellence program:

- Services must be scheduled and preauthorized by one of the Plan's administrators for the Centers of Excellence program in order to be covered under the Plan. The particular administrators from whom preauthorization

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CENTERS OF EXCELLENCE

| | Centers of Excellence Providers | Your Medical Plan Network | Out-of-Network *Out-of-network benefits not available under Accountable Care Plans and Select Network Plan* |
|---|---|---|---|
| **Heart surgery** | 100% *No deductible** | 75% *After deductible* | 50% *After deductible* |
| **Breast, lung and colorectal cancer medical record review** (Onsite travel if recommended) | | | |
| **Spine surgery** | 100% *No deductible** | 50% After deductible *(Subject to out-of-network deductible for HRA Plan, HRA High Plan and HSA Plan; network deductible for Accountable Care Plan and Select Network Plan)* | 50% *After deductible* |
| **Hip and knee replacement** | | | |
| **Transplant** (Mayo Clinic only. Excludes kidney, cornea and intestinal transplant) | 100% *No deductible** | No coverage** | No coverage** |
| **Weight loss surgery** (Gastric bypass and gastric sleeve) | 75% *After deductible* | No coverage** | No coverage** |

*Due to federal tax law, participants in the HSA Plan must meet their annual deductible before 100% benefits can be provided.

**See the adjacent Centers of Excellence text for circumstances when exceptions may apply.

Additional program conditions and restrictions are described in the adjacent Center of Excellence text.

must be obtained will vary, depending on the specific Centers of Excellence service to be provided and in certain cases the associate's medical coverage, as listed in the Centers of Excellence administration chart below.

- If your request for preauthorization of a Centers of Excellence service is denied, you have the right to appeal that denial. See the Claims and appeals chapter for more information. Note that services performed at a Centers of Excellence facility that are not covered services under the terms and conditions of the Centers of Excellence program will be subject to regular coverage and payment terms under the Associates' Medical Plan.
- For most eligible services, the participant must identify a designated caregiver who must agree to (and be able to) meet caregiver requirements.
- The participant must be safe to travel for medical care and must not require emergency care at the time of travel.
- The medical center in which the participant will receive services is determined by geographical location of residence and indicated service.
- The participant acknowledges that the medical center must receive necessary medical records prior to acceptance into the program.
- The participant must supply contact information for a local physician who has agreed to manage follow-up care after the participant returns home from the Centers of Excellence facility.

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CENTERS OF EXCELLENCE ADMINISTRATION

**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 medical record review** (Onsite travel if recommended) | **HealthSCOPE Benefits** |
| **Spine surgery** | **Health Design Plus** |
| **Hip and knee replacement** | **Health Design Plus** |
| **Transplant** (Mayo Clinic only. Excludes kidney, cornea and intestinal transplant) | **HealthSCOPE Benefits** |
| **Weight loss surgery** (Gastric bypass and gastric sleeve) | **Health Design Plus** |

Travel, lodging and a daily allowance will be provided for the recipient and a caregiver for all services covered under the Centers of Excellence program except weight loss surgery. These travel services must be pre-authorized and scheduled through the Centers of Excellence program. Payment is subject to otherwise applicable limits.

**NOTE:** Travel benefits may not be available in certain circumstances if you are enrolled in one of the Accountable Care Plan options.

If a medical director of a Third Party Administrator recommends that a Plan participant be treated at a specific facility based on the individual's condition, even if this facility is not a Centers of Excellence facility, the Plan will cover the same travel benefits as those paid for travel to a Centers of Excellence facility. These travel services must be pre-authorized by the Third Party Administrator's medical director and scheduled through the Plan. Reimbursement for medical treatment or services at the facility will be paid under otherwise applicable Plan terms, and will not be reimbursed as Centers of Excellence services at the rates listed in the chart on the previous page.

If you believe you may be a candidate to participate in the Centers of Excellence program, call your health care advisor at the phone number on your plan ID card.

If you have a medical condition that is eligible for care under the Centers of Excellence program and you choose to receive treatment in a facility outside the Centers of Excellence program, your care will not be covered at the Centers of Excellence rates, but instead will generally be subject to the regular coverage terms under the Associates' Medical Plan. These terms are summarized in the Centers of Excellence chart on the previous page and described in greater detail in Administration of the Associates' Medical Plan earlier in this chapter. Similarly, services you receive prior to arrival or following discharge from a Centers of Excellence facility, including those approved by the Centers of Excellence program administrator, will be subject to regular coverage terms under the Plan.

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**NOTE:** In cases of spine surgery or hip or knee joint replacement, if you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, the Plan will pay 50%, subject to the following limitations:

- If you have coverage under the HRA High Plan, HRA Plan or the HSA Plan and have your procedure performed by a network provider, you will be subject to the out-of-network deductible before benefits are payable.
- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by a network provider, you will be subject to your plan's annual deductible.



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- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by an out-of-network provider, no benefits will be payable.

**Requests for exceptions to Plan coverage terms for spine surgery and hip and knee replacement**

In cases of spine surgery and hip and knee replacement, you may request an exception to the rules described above, which state how the Plan will cover these procedures when they are performed outside the Centers of Excellence program. You may request an exception so that procedures performed by a network provider that is not a Centers of Excellence network provider be covered at a coinsurance rate of 75% of the network discounted rate. Depending on whether you have already received treatment when you make your request, it will be treated as a pre-service claim or post-service claim (as described below) and decided under special rules for granting exceptions to the Plan's coverage terms for spine surgery and hip and knee replacement under the Centers of Excellence program, as described in the Claims and appeals chapter.

**Pre-service exception request:** If you have not yet received treatment but are considering receiving services from a non-Centers of Excellence provider, you may file a prior authorization request (a pre-service claim) to have spine surgery or hip or knee replacement performed by a provider who is not a Centers of Excellence provider if travel to the Centers of Excellence provider would likely result in loss of life, paralysis or further injury, or if the Centers 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 you are not an appropriate candidate for surgery. Your request will be considered by an Independent Review Organization following the procedures described under Special procedures for approval of exceptions to Plan coverage terms for spine surgery and hip and knee replacement in the Claims and appeals chapter. If your request is granted, coverage will be at the otherwise applicable network rate, including any deductibles, coinsurance or limitations. If your request is denied because the Independent Review Organization determines that travel to a Centers of Excellence provider is safe, based on the documentation received, coverage at a non-Centers of Excellence facility will be paid at 50% as outlined above.

Decisions not to move forward with spine surgery or hip or knee replacement by the respective Centers of Excellence providers will not be subject to review under this process if the Centers of Excellence provider's decision is based on a determination that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support or similar factors.

**Post-service exception request:** If you already have received services from a non-Centers of Excellence provider, you may file a post-service claim with your Third Party Administrator, as described in the Claims and appeals chapter. Your claim may be approved if:

- You experienced a traumatic injury resulting in the need for immediate surgery or were in need of immediate surgery, without which you would have likely incurred loss of life or paralysis, or
- Services were provided by a network provider that began a course of treatment prior to January 1, 2017 and there has not been an interruption of the doctor-patient relationship.

If your claim is approved, coverage will be at the otherwise applicable network or non-network rate, depending on your provider, including any deductibles, coinsurance or limitations. If your claim is denied, you may request an appeal as described in the Claims and appeals chapter.

## LIMITED COORDINATION OF BENEFITS

The Associates' Medical Plan generally does not coordinate benefits with respect to claims under the Centers of Excellence program, other than coordination with Medicare in the case of certain transplant benefits or as otherwise required by law. For all other Centers of Excellence services, if any portion of a Centers of Excellence benefit could have been paid by another health plan, the Associates' Medical Plan will not pay any amount of the claim.

## TRANSPLANTS

To be eligible for transplant and lung volume reduction surgery (LVRS) benefits under the Centers of Excellence program, participants must be enrolled in the Associates' Medical Plan for at least 12 months. Associates enrolled in the eComm PPO Plan or an HMO plan are not eligible for transplant benefits, but if they later become covered under one of the plans available under the Associates' Medical Plan, their time enrolled in the eComm PPO Plan or an HMO will count toward the 12-month waiting period. For associates not enrolled in one of the plans available under the Associates' Medical Plan, any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.

The 12-month waiting period will not apply to insertion of durable ventricular assist devices (VADs) or artificial hearts, regardless of whether the VAD is related to a transplant.

The 12-month waiting period applies to the associate and, separately, to most covered dependents — i.e., the covered associate and each covered dependent must meet his or her own 12-month waiting period. If the covered associate adds coverage under the Plan for a new dependent through birth, or adoption of the child as of the child's date of birth, the new dependent's 12-month waiting period will be waived.

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The 12-month waiting period will be waived for localized associates and their covered dependents. In addition, the 12-month waiting period may be waived in cases where your doctor certifies that in the absence of a transplant, the covered participant's death is imminent within 48 hours. See the Claims and appeals chapter for information on requesting a waiver.

If your doctor recommends a transplant, please call HealthSCOPE Benefits at 479-621-2830 or 800-421-1362.

**Guidelines for covered transplants**

- All associates and dependents enrolled for coverage under the Associates' Medical Plan who are transplant recipients (except for kidney, cornea and intestinal recipients) must undergo a pretransplant evaluation at Mayo Clinic. In performing this evaluation, Mayo Clinic is not acting as an agent of the Plan. It is the Plan's intent that this evaluation be made pursuant to the doctor/patient relationship between Mayo Clinic and the participant. Travel, lodging and a daily allowance will be provided for the recipient and a caregiver for required transplant evaluations at Mayo Clinic.
- Liver, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung, pancreas, simultaneous kidney/pancreas, multiple organ, lung volume reduction surgery (LVRS) and bone marrow/stem cell transplants must be performed at Mayo Clinic or an approved facility, or no benefits will be paid unless travel will result in death.
- Claims for eligible transplant services performed at Mayo Clinic (including pediatric) should be filed with HealthSCOPE Benefits and are covered at 100% with no annual deductible. However, if you are enrolled in the HSA Plan, you must meet your annual deductible before the Plan will make any payments due to federal tax laws. Additionally, travel, lodging and a daily allowance will be provided for the recipient and a caregiver. Payment is subject to otherwise applicable limits.
- The Plan does not cover the transplantation of body parts (e.g., face, hands, feet, legs, arms) under any circumstances. Experimental and/or investigational transplant-related services are not covered unless those services are recommended and performed by Mayo Clinic or an approved facility.
- Benefits for a covered transplant procedure at Mayo Clinic and related expenses, including travel, lodging and a daily allowance, will end one year post-transplant or after a one-year post-transplant evaluation is performed.
- Coverage for procedures and devices unrelated to a transplant, as determined by Mayo Clinic, are not covered at 100% and will be subject to the otherwise applicable Plan terms and limitations, including annual deductibles and coinsurance (network and out-of-network). This will include certain gastric-sleeve procedures performed at Mayo Clinic during a liver transplant.
- Non-transplant services performed at Mayo Clinic are not covered at 100% and will be subject to the otherwise applicable Plan terms and limitations, including annual deductible and coinsurance (network and out-of-network).
- Travel for transplant-related services must be arranged by a transplant coordinator. For travel arrangements, please call HealthSCOPE Benefits at 479-621-2830 or 800-421-1362.
- Claims for transplants and LVRS that are not performed in accordance with the guidelines stated in this chapter and in the Claims and appeals chapter will be denied.
- Coverage is limited to transplantation of human organs.

**Requests for organ transplants at facilities other than Mayo Clinic**

- You may file a claim with an Independent Review Organization to request an organ transplant at a facility other than Mayo Clinic if:
  - There is significant risk that travel to Mayo Clinic could result in death, or
  - Mayo Clinic determines that it will not recommend and perform a transplant because it is not the appropriate medical course of treatment or you are not an appropriate candidate for a transplant.

Your claim must be received by the Plan within 120 calendar days of the initial denial of the transplant by Mayo Clinic. Your claim will be decided under the special rules for transplant claims at a facility other than Mayo Clinic, as described in the Claims and appeals chapter.

- The Independent Review Organization will be made up of individuals appointed by the Plan Administrator and will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Organization will review any relevant medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures and the potential benefit the transplant would have.
- If the Independent Review Organization determines that the transplant and related course of treatment are medically necessary, the Independent Review Organization will approve an exception to pursue a transplant outside of Mayo Clinic, under regular medical benefits.
- Claims will be covered at 75% for network providers after the annual deductible has been met.
- If you are enrolled in the HRA High Plan, HRA Plan or HSA Plan, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share

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plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator, or when Mayo Clinic or the Independent Review Organization determines that the services are medically necessary.)

- The Plan will not cover the cost of travel or lodging or provide a daily allowance for such transplants.

Transplant denials by Mayo Clinic will not be subject to review under this process if Mayo Clinic's decision is based on a determination that the transplant is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support or similar factors. Any transplant-related claims where treatment has already been rendered will be decided under the regular medical claims and appeals procedures found in the Claims and appeals chapter.

**Pediatric transplant recipients under age 19**

- Pediatric transplant recipients under age 19 (except for kidney, cornea and intestinal transplants) must undergo a pre-transplant review and, upon request by Mayo Clinic, an evaluation by Mayo Clinic.
- Claims will be covered at 75% for network providers after the annual deductible has been met.
- If your medical plan option provides coverage for non-network providers, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator.)
- Travel, lodging and a daily allowance will be provided only if the transplant is performed at Mayo Clinic.

**Transplant donor expenses**

- Eligible transplant donor expenses with respect to a living donor are covered when the recipient is an Associates' Medical Plan participant who is eligible for transplant coverage and the living donor's medical plan or insurance provider does not pay for transplant donor charges and/or expenses.
- Eligible transplant donor expenses with respect to travel and lodging benefits must be arranged by a transplant coordinator. It is the responsibility of the transplant recipient to provide the contact information for the transplant benefit administrator to the eligible transplant donor, prior to appointments.
- Covered donor charges will be paid at the same benefit level as the recipient according to the transplant guidelines previously stated, up to 120 days post-transplant.
- Cadaver organ acquisition and procurement expenses are covered only when the expenses are part of the provider's base contracted rate with the Plan's Third Party Administrator.

## WEIGHT LOSS SURGERY BENEFIT

Certain weight loss surgeries are covered under the Associates' Medical Plan Centers of Excellence program, subject to specific criteria, including but not limited to:

- Services must be provided by a physician and facility designated by the Plan

### KIDNEY, CORNEA AND INTESTINAL TRANSPLANTS

Kidney, cornea and intestinal transplants are not included in the Centers of Excellence transplant program and can be performed at the network facility of your choice, according to these terms:

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

- If your medical plan option provides coverage for non-network providers, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator.)
- No travel, lodging or daily allowance will be provided for these transplants (even if performed at Mayo Clinic).

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- The participant wishing to utilize the weight loss surgery benefit must be enrolled for medical benefits in the Associates' Medical Plan for one continuous year before becoming eligible for the benefit and must be willing to travel to the facility designated by the Plan at their own expense (travel reimbursement is not provided)
- You must be an associate or an eligible covered spouse/partner of an associate (coverage is not available to dependent children, regardless of age)
- You must be at least 18 years of age
- You must have a body mass index (BMI) of 40 or greater
- You must currently be diagnosed with type 2 diabetes, and
- You must agree to comply with all requirements for the duration of the weight loss surgery treatment.

Coverage for weight loss surgery is provided at the network benefit level; after your annual deductible for eligible network expenses is met, the Plan pays 75% and you pay 25%. If you meet the requirements stated above and your doctor recommends weight loss surgery, please call your health care advisor at the number on your plan ID card to obtain a Request Form, which must be completed by you and your physician. You must send the completed Request Form to Health Design Plus at the address listed on the form. A claim will be considered filed when the Request Form is received by Health Design Plus. The claim will be determined under the procedures for pre-service claims described in the **Claims and appeals** chapter.

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## When limited benefits apply to the Associates' Medical Plan

Some services are also subject to specific restrictions and limitations in addition to annual deductible and coinsurance/copayment requirements, as described below. If you have a question on the coverage of a particular service, please contact the Third Party Administrator. Contact information is provided on your plan ID card.

The limitations and restrictions described are in addition to other Plan rules, including annual deductibles, coinsurance/copayments and exclusions. Consideration may be given for additional coverage when authorized by your nurse care manager, as described in the **Care management** section.

Please refer also to **What is not covered by the Associates' Medical Plan**, later in this chapter.

### AMBULANCE

Coverage of ambulance or air ambulance transportation is limited to the nearest hospital or nearest treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety.

The Plan covers ambulance or air ambulance transportation between health care facilities if the treatment being provided at the second facility is medically necessary and not available at the initial facility.

The Plan covers ambulance and air ambulance transportation from a hospital to a hospice facility (including to a residence where hospice care will be provided).

**Ambulance not covered:** Ambulance charges for the sole convenience of the participant, caregiver or provider will not be covered.

### BIRTH CONTROL/CONTRACEPTIVES

Prescribed FDA-approved contraceptive methods for women and female sterilization are covered under women's preventive care, including but not limited to:

- Diaphragms: fitting and supply
- Cervical cap: fitting and supply
- Intrauterine device (IUD): fitting, supply and removal (including copper or with progestin)
- Birth control pills (including the combined pill, progestin-only, and extended/continuous use)
- Birth control patch
- Vaginal ring
- Injection (e.g., Depo-Provera) given by a physician or nurse every three months
- Implantable contraception (e.g., Implanon)
- Plan B, when prescribed
- Ella, when prescribed
- Female sterilization (including surgery and surgical sterilization implant)
- Vaginal sponge, when prescribed
- Female condom, when prescribed
- Spermicide, when prescribed.

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The Plan will cover generic contraceptives only when prescribed by a physician (and brand-name contraceptives when medically necessary). If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug.

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

- Abortion
- Prescription abortifacient medication, including but not limited to RU-486
- Male sterilization
- Over-the-counter birth control methods that are not prescribed, including but not limited to Plan B, spermicides, condoms, vaginal sponges, basal thermometers and ovulation predictor kits.



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## CLINICAL TRIALS

Routine patient costs otherwise covered by the Plan that are associated with participation in Phases I–IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable deductibles and limitations and do not include costs of the investigational item, device or service, items that are provided for data collection, or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

## DURABLE MEDICAL EQUIPMENT (DME)/HOME MEDICAL SUPPLIES

Durable medical equipment (DME) that satisfies all of the following criteria is covered under the Plan, unless listed below under DME not covered. DME is equipment that:

- Can withstand repeated use
- Is used mainly for a medical purpose rather than for comfort or convenience
- Generally is not useful to a person in the absence of an illness or injury
- Is related to a medical condition and prescribed by a physician
- Is appropriate for use in the home, and
- Is determined to meet medical criteria for coverage to diagnose or treat an illness or injury, help a malformed part of the body to work well, help an impaired part of the body to work within its functional parameters or keep a condition from becoming worse.

Coverage is also provided for home medical supplies, such as ostomy supplies, wound-care supplies, tracheotomy supplies and orthotics. Supplies must be prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.) to be covered. Surgical stockings are limited to 12 stockings per calendar year.

To be covered, a doctor must include a diagnosis, the type of equipment needed and expected time of usage. Examples of DME include wheelchairs, hospital-type beds and walkers. If equipment is rented, the total benefit may not exceed the purchase price at the time rental began.

Repair of DME is covered when all the following are met:

- The patient owns the equipment
- The required repairs are not caused by the patient's misuse or neglect of the equipment
- The expense of the repairs does not exceed the expense of purchasing a new piece of equipment, and
- The equipment is not currently covered by warranty.

If the patient-owned DME is being repaired, up to one month's rental for that piece of DME will be covered. Payment is based on the type of replacement device that is provided, but will not exceed the rental allowance for the equipment that is being repaired.

**DME not covered:** Motor-driven scooters, invasive implantable bone growth stimulators (except in the case of spinal surgeries), sitz bath, seat lift, rolling chair, vaporizer, urinal, ultraviolet cabinet, whirlpool bath equipment, bed pan, portable paraffin bath, heating pad, heat lamp, steam/hot/cold packs, devices that measure or record blood pressure and other such medical equipment or items determined to be not medically necessary.

## FOOT CARE

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

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

Services must be prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.) or doctor of podiatric medicine (D.P.M.).

Open cutting surgical care (including removal of nail roots) and nonsurgical care due to metabolic and peripheral vascular disease are not subject to the calendar year limit.

Orthotic devices for the feet may be covered if prescribed by a qualified doctor and custom-molded under the doctor's supervision, subject to the calendar-year limit described above. Orthopedic shoes prescribed by a doctor are limited to two shoes per calendar year.

## GENDER DYSPHORIA TREATMENT

The Plan covers medically necessary benefits for the treatment of gender dysphoria. If medically necessary, the following benefits are covered:

- Gender reassignment surgery, including both male to female surgery and female to male surgery
- Hormone replacement therapy, including laboratory testing to monitor hormone therapy, and
- Psychotherapy visits.

Gender reassignment surgery will be covered only if you are age 18 or older. The Plan will not cover cosmetic treatment of gender dysphoria.

## HOME NURSING CARE

In-home private-duty professional nursing services will be covered if provided by a state-approved licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.) or registered nurse (R.N.). Services cannot be rendered by a relative or by someone in the same household as the patient. Home nursing care benefits are payable up to a maximum of 100 visits per calendar year. A visit is defined as two hours or less.

## HOSPICE CARE

Hospice care is an integrated program providing comfort and support services for the terminally ill. Hospice care is covered for participants with an estimated life expectancy of 12 months or less, as attested by the physician treating the illness. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and support for immediate family members, including partners, while the covered person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Inpatient and outpatient hospice care are covered up to 365 days per illness. Participants may continue to receive treatment and participate in approved clinical trials while obtaining hospice services. Coverage for additional days may be available if determined to be medically necessary.

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## INFERTILITY TREATMENT

Services for the diagnosis and correction of an underlying condition of infertility are covered. Refer to **What is not covered by the Associates' Medical Plan** later in this chapter for a list of non-covered infertility services.

## INTERNATIONAL BUSINESS TRAVEL MEDICAL COVERAGE

Walmart provides international business medical insurance through an insurance policy from GeoBlue. If you participate in the HSA Plan, 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, which provides health benefit coverage for Walmart associates traveling internationally on business. 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.

## NUTRITIONAL COUNSELING

Nutritional counseling for children is covered if it is medically necessary for a chronic disease (e.g., PKU, Crohn's disease, celiac disease, galactosemia, etc.) in which dietary adjustment has a therapeutic role when it is prescribed by a physician and furnished by a provider (e.g., a registered dietician, licensed nutritionist or other qualified licensed health professional) recognized under the Plan. Benefits are limited to three visits per condition per year. Please see the **Preventive care program** section for additional benefits related to nutritional and obesity counseling for adults and children.

## OFF-LABEL USE OF CANCER CHEMOTHERAPY INJECTABLE DRUGS

These drugs will be considered to meet coverage criteria when they are medically necessary as defined by the Plan, recommended by one of the following three drug compendia, and not recommended against by one or more of the same compendia (appropriate to the date of service):

- *American Hospital Formulary Service (AHFS) Drug Information*
- Clinical Pharmacology Online, or
- National Comprehensive Cancer Network (consensus) or category 1 (the recommendation is based on high-level evidence and there is uniform NCCN consensus) or category 2A (the recommendation is based on lower-level evidence and there is uniform NCCN consensus).

If you or your physician are unsure about the Plan's coverage for any type of prescription drug, verify coverage details by calling the Third Party Administrator of your medical plan at the number on your plan ID card. You can also call Express Scripts at **800-887-6194**.

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## OFF-LABEL USE OF NON-CANCER CHEMOTHERAPY INJECTABLE DRUGS

These drugs will be considered to meet coverage criteria when they are medically necessary as defined by the Plan and recommended under one of the following drug compendia (appropriate to the date of service):

- *American Hospital Formulary Service (AHFS) Drug Information*, or
- Clinical Pharmacology Online.

The Plan will not cover any drug when the FDA has determined its use to be contra-indicated or not advisable. Coverage for FDA-approved drugs will be subject to the Plan's otherwise applicable requirements and limitations.

## ORAL TREATMENT

Charges for the care of teeth and gums are covered by the Associates' Medical Plan when submitted by a doctor or dentist, including but not limited to:

- Prescriptions
- Emergency room services for mouth pain
- Treatment of fractures/dislocations of the jaw resulting from an accidental injury



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- Accidental injury to natural teeth up to one year from the date of the accident (does not include injuries resulting from biting or chewing; those may be covered under the dental plan)
- Dental procedures that are necessitated by either severe disease (including but not limited to cancer) or traumatic event, as long as the dental service is medically necessary and the service is incidental to and an integral part of service covered under the medical benefits of the Plan. Examples of services include, but are not limited to, the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
- Non-dental cutting procedures in the oral cavity
- Medical complications that are the result of a dental procedure, or
- Expenses for dental services performed in a hospital setting, including facility and professional charges, for extensive procedures that prevent an oral surgeon from providing general anesthesia in an office setting, or for circumstances that limit the ability of the oral surgeon to provide services in an office setting. Such circumstances include, but are not limited to, situations in which the covered person is:
  - A child under age 4
  - Between the age of 4 and 12, when either:
    - Care in a dental office has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or
    - Extensive amounts of care are required, exceeding four appointments.
  - An individual with one of the following medical conditions, requiring hospitalization or general anesthesia for dental treatment:
    - Respiratory illness
    - Cardiac conditions
    - Bleeding disorders
    - Severe disability (including but not limited to cerebral palsy, autism, developmental disability)
    - Other severe disease (including but not limited to cancer or neurological disorder), or
    - Compromised airway.
  - An individual of any age whose condition requires extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting.

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### OUTPATIENT PHYSICAL/OCCUPATIONAL THERAPY

Charges for outpatient physical/occupational therapy are covered when services are:

- Prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.) or doctor of podiatric medicine (D.P.M.), and
- Provided by a licensed physical therapy provider or licensed occupational therapy provider or by one of the types of doctors listed above.

This benefit is payable up to a maximum of 20 visits for physical therapy and 20 visits for occupational therapy per calendar year. Additional visits may be covered if deemed appropriate by the care manager.

### PREGNANCY BENEFITS

Pregnancy expenses are covered the same as any other medical condition. (Eligible prenatal services are covered under the preventive care program.)

Benefits will be paid for pregnancy-related expenses of dependent children. The newborn will be covered only if the newborn is a covered dependent of the covered associate. See How to change your elections due to a status change event in the Eligibility and enrollment chapter for information on enrolling a newborn for coverage.

### PROSTHETICS

Prosthetic devices (such as artificial limbs) are covered if medically necessary and prescribed by a physician, subject to the terms of the Third Party Administrators of the Plan. Replacement prostheses will be allowed only with a change of prescription. A licensed prosthetician must perform replacements of artificial limbs.

### REHABILITATIVE CARE

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

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

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### SPECIALTY CARE

Medical care commonly provided at the following types of facilities is covered if the participant is admitted to this level of care subsequent to an eligible acute care hospital confinement:

- Extended care facility
- Long-term acute care specialty facility
- Subacute care facility
- Skilled nursing facility, or
- Transitional care facility.

Benefits are limited to a maximum of 60 calendar days per disability period.

Successive periods of confinement due to the same or related causes are considered one disability period unless separated by a complete recovery.

### SPEECH THERAPY

Therapy of up to 60 visits per calendar year is covered when:

- Prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.), and
- Provided by a licensed speech therapist.

An initial plan of treatment, ongoing plan of treatment and progress reports may be requested from the prescribing doctor. To be covered, speech therapy must be for a residual speech impairment resulting from:

- A cerebral vascular accident
- Head or neck injury
- Paralysis of voice cord(s) or larynx, partial or complete
- Head or neck surgery, or
- Congenital and severe developmental speech disorders in children up to age 6.

### VIDEO VISITS

Video visits are covered for participants enrolled in the Associates' Medical Plan only when provided through the Doctor On Demand service. See Telehealth video visits earlier in this chapter for more information.

### VISION SERVICES

The diagnosis and treatment of injury or disease of the eye, including but not limited to diabetic retinopathy, glaucoma and macular degeneration, are covered. Charges for routine eye care, including but not limited to vision analysis, eye examinations or eye surgeries for nearsightedness or correction of vision, are not covered, except for vision screening for children covered under preventive care guidelines.

### WEIGHT LOSS TREATMENT

Weight loss surgery is covered by the Associates' Medical Plan only when participants meet specific eligibility guidelines and clinical criteria under the Centers of Excellence program. Weight loss treatments, including but not limited to medications, diet supplements and surgeries outside the scope of the weight loss surgery benefit are not covered. See the Centers of Excellence section of this chapter for more information about weight loss surgery.

## What is not covered by the Associates' Medical Plan

In addition to the exclusions and limitations listed in the When limited benefits apply to the Associates' Medical Plan section of this chapter, the following list represents services and charges that are not covered by the Plan and cannot be paid through your HRA (if you are covered under one of the HRA plans). Network discounts will not apply to these services and charges.

If you are enrolled in the HSA Plan, you may be able to use your Health Savings Account funds for these and other qualified medical expenses. For more information, contact your Health Savings Account administrator.

If you have a question regarding whether a particular service is covered under the Plan, please call the Third Party Administrator on your plan ID card or see the inside back cover of this book for contact information.

**Acupuncture**

**Administrative services and interest fees:** Charges for the completion of claim forms, missed appointments, additional charges for weekend or holiday appointments, interest fees, collection fees or attorneys' fees.

**Alternative/nontraditional treatment** (including homeopathy, naturopathy, hypnosis and massage therapy).

**Autopsy**

**Beyond the scope of licensure or unlicensed:** Services rendered by a non-credited or a non-licensed physician, health care worker or institution, or services rendered beyond the scope of such person or entity's license.

**Biofeedback**

**Breast reconstruction/reduction:** Any expenses or charges resulting from breast enlargement (augmentation), including implant insertion and implant removal, whether male or female, are not covered except when the implant is removed as the result of implant damage or rupture. Replacement of a damaged or ruptured implant is not covered unless the original implant was placed for conditions eligible to be paid by the Plan.

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Any expenses or charges resulting from breast reductions, implantations or total breast removal, whether male or female, are not covered, unless directly related to treatment of a mastectomy, as provided for under the Women's Health and Cancer Rights Act of 1998 (see Women's Health and Cancer Rights Act of 1998 later in this chapter), or unless the Plan conducts a medical review and determines that the procedure is medically necessary.

**Chiropractic care:** Coverage for spinal manipulation, joint manipulation or soft-tissue manipulation, regardless of the type of provider performing the service, except that participants enrolled in the Mercy Accountable Care Plans for Arkansas, Oklahoma, Springfield and St. Louis have limited coverage when services are performed by a network provider.

**Copays and/or discounts, deductibles and/or coinsurance**

**Cosmetic health services or reconstructive surgery:** Except for congenital abnormality, for services covered under the Women's Health and Cancer Rights Act of 1998 (see Women's Health and Cancer Rights Act of 1998 later in this chapter), or for conditions resulting from accidental injuries, tumors or diseases.

**Custodial or respite care:** Custodial care is services that are given merely as "care" in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

**Drugs, items and equipment not FDA-approved**

**Educational services:** Including any services for learning and educational disorders (which include but are not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders and other learning difficulties).

**Elective inpatient and outpatient stays or services outside the U.S.**

**Expenses related to missed appointments, review or storage of your health care information or data**

**Experimental, investigational and/or treatments and services that are not medically necessary:** Experimental and/or investigational medical services are those defined as experimental and/or investigational according to protocols established by your Third Party Administrator. For purposes of Centers of Excellence services, the Center of Excellence Third Party Administrator makes this determination.

**Extracorporeal shock wave therapy:** For plantar fasciitis and other musculoskeletal conditions.

**Government compensation:** Charges that are compensated for or furnished by local, state or federal government or any agency thereof, unless payment is legally required.

**Health and behavior assessment/intervention:** Evaluation of psychosocial factors potentially impacting physical health problems and treatments except behavioral assessments outlined under the preventive care program.

**Hearing devices:** Charges for routine hearing tests, including but not limited to hearing aids, except for hearing screening for children, covered under preventive care guidelines.

**HMO copays**

**Illegal occupation, assault, felony, riot or insurrection:** Charges for medical services, supplies or treatments that result from or occur while being engaged in an illegal occupation, commission of an assault, felony or criminal offense (except for a moving violation), or participation in a riot or insurrection.

**Infertility services:** Treatment by artificial means for the purpose of creating a pregnancy. Assistive reproductive technology (ART) and other non-covered services include but are not limited to:

- Infertility prescription drugs
- Charges to reverse a sterilization procedure
- Charges for, or related to, the services of a surrogate mother, egg donor or sperm donor, and
- In-vitro fertilization, GIFT, ZIFT, IVC, gamete intra-cryopreservation, frozen embryo transfer and artificial insemination, including all related charges.

**Judgments/settlements**

**Late claims:** Charges received more than 18 months past the date of service. See Filing a medical claim later in this chapter for information about coordination of benefits. In the event a participant establishes that a claim was filed within the stated time period, but the claim was mistakenly filed with the company or any Third Party Administrator of the Plan, that time shall not count toward the filing period above.

**Marital, family or relationship counseling:** Or counseling to assist in achieving more effective intra- or interpersonal development.

**Military-related injury or illness:** Including injury or illness related to, or resulting from, acts of war, declared or undeclared.

**Neurofeedback**

**Nonaccredited/nonlicensed providers or institutions**

**Non-covered services:**

- Services not specifically included as a benefit in this Summary Plan Description
- Services provided after exceeding the benefit maximum for specified services
- Services for which the participant is responsible for payment, such as non-covered out-of-network charges
- Charges for services above the contracted rates to providers, or
- Charges for medical records.

**Out-of-pocket expenses**

**Over-the-counter medications and equipment:** Except for specific preventive care medications. See The pharmacy benefit chapter for more information.

**Personal care items:** Primarily for personal comfort or convenience, including but not limited to diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, bedboards, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs and knee braces for sports.

**Prostate-specific antigen (PSA) tests**

**Services provided by a member of the patient's family**

**Services provided by a government entity while incarcerated**

**Sexual dysfunction services and pharmaceuticals:** Including therapy, treatment or pharmaceuticals for the treatment of sexual dysfunction, except for sexual dysfunction that is the result of an accidental injury or that results from treating an illness or condition (e.g., erectile dysfunction resulting from a prostatectomy or spinal cord injury).

**Sports/school physicals:** Charges for physical examinations performed for the purpose of clearing an individual for participation in a sport or school activity.

**Surrogate parenting:** Whether paying for another's services or serving as a surrogate.

**Talking aids:** Assistive talking devices, including special computers or advanced technological assistance devices designed to assist in therapy treatment to enhance motor and/or psychological abilities.

**Termination of pregnancy:** Charges for procedures, services, drugs and supplies related to abortions or termination of pregnancy are not covered, except when the health of the mother would be in danger if the fetus were carried to term, the fetus could not survive the birthing process or death would be imminent after birth.

**Travel and lodging, except as specified under Centers of Excellence benefits (excluding weight loss surgery)**

**Vitamins:** Charges for nonprescription vitamins (whether oral or injectable), minerals, nutritional supplements or dietary supplements, except as outlined in the Preventive care program section of this chapter.

**Walmart Care Clinic:** Charges for nonpreventive services, except where the Walmart Care Clinic is considered a network provider or for lab services provided outside the clinic by an external vendor.

**Work hardening or similar vocational programs**

**Workers' compensation:** Treatment of any compensable injury, as defined by applicable workers' compensation law, is not covered, regardless of whether or not you filed a timely claim for workers' compensation benefits.

## Filing a medical claim

If you use a network provider, the provider will generally file the claim for you. If you see a non-network provider, you may need to file a claim. If you need to file a claim, the claim should include the following information:

- Patient's name
- Provider's name, address and tax identification number
- Associate's insurance ID (see your plan ID card)
- Date of service
- Amount of charges
- Medical procedure codes (these should be found on the bill), and
- Diagnosis.

You must file within 18 months from date of service or your claim will be denied. Claims will be determined under the time frames and requirements outlined in the Claims and appeals chapter.

Please see your plan ID card for the correct address to mail your claim. Failure to mail your claim to the correct address may result in the denial of your claim.

In addition, you may complete a claim form located on the WIRE or WalmartOne.com and submit the form to the appropriate address.

Failure by you or the provider to file a claim within 18 months from the date of service will result in denial of your claim. There are laws that govern the review of your claims.

Claims will be determined under the same time frames and requirements set out in the Claims and appeals chapter.

When you incur medical expenses and a claim is filed, benefits will be paid directly to the provider for network services. Payment to the provider discharges the Plan's obligation to you for the benefit.

If your plan provides coverage for non-network providers and you use a non-network provider, payment may be made directly to you upon your showing proof of payment in full to the provider. You will be responsible for your 50% share of the maximum allowable charge, plus any amount over and above the maximum allowable charge. As a convenience to you, payment may also be made to a non-network provider, if you expressly authorize such payment. Your provider, whether network or non-network, may not pursue appeals on your behalf unless you designate your provider as your authorized representative, as described in the Claims and appeals chapter. The Plan prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). Please note that any direct payment to a provider is undertaken by the Plan solely for your convenience.

You have the right to appeal a claim denial. See the Claims and appeals chapter for details.



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## If you have coverage under more than one medical plan

The Associates' Medical Plan has the right to coordinate with "other plans" under which you are covered so the total medical benefits payable will not exceed the level of benefits otherwise payable under the Associates' Medical Plan. "Other plans" refers to the following types of medical and health care benefits:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation
- Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare or Tricare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program, and
- Any private or association policy or plan of medical expense reimbursement that is group or individual rated.

When you are covered by more than one plan, one of the plans is designated the primary plan. The primary plan pays first and ignores benefits payable under other plans when determining benefits. Any other plan is designated as a secondary plan that pays benefits after the primary plan. A secondary plan reduces its benefits by those benefits payable under "other plans" and may limit the benefits it pays.

You must follow the primary insurance terms in order for the Plan to pay as secondary payer.

These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the Associates' Medical Plan will be delayed or denied until an explanation of benefits is received showing a claim made with the primary plan.

The Associates' Medical Plan will not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims or transplants (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage or medical payment coverage is mandatory, that coverage is primary and the Plan takes secondary status. The Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

- The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.
- The Plan will not coordinate benefits with an HMO or similar managed care plan where you pay only a copayment or fixed dollar amount.
- The Plan will not coordinate with any other plan other than Medicare with respect to a covered transplant.

HOW THE ASSOCIATES' MEDICAL PLAN (AMP) COORDINATES WITH OTHER PLANS

| | Example 1 | Example 2 | Example 3 |
|---|---|---|---|
| If another plan pays primary at: | 80% | 80% | 0% |
| And the AMP's payment is: | 75% | 100% | 75% |
| The AMP's total benefit is: | 0% | 20% | 75% |

### DETERMINING WHICH PLAN IS THE PRIMARY PLAN

A plan without a coordinating provision is always primary. The Associates' Medical Plan has a coordinating provision. If all plans have a coordinating provision, the following will apply:

- The Plan always is the secondary payer to any motor vehicle policy that may be available to you, including personal injury protection or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses you sustained and another party (e.g., an insurance company) bears primary responsibility for your covered medical expenses, the Plan has a legal right to reimbursement of benefits. Please see the Claims and appeals chapter for more information.
- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- If the plan participant is covered under a retiree medical plan that includes a coordination of benefits provision, the provision governs.
- For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.
- When the parents of a dependent child are divorced or separated, or the domestic partnership or legal relationship is terminated, and the parent with custody has not remarried, that parent's plan is primary.
- When the parent with custody has remarried, or entered into a domestic partnership with another individual, that parent's plan is primary, the stepparent's plan pays second and the plan of the parent without custody pays last.
- When there is a court decree that establishes financial responsibility for the health care expenses of the

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child, the plan that covers the parent with financial responsibility is primary.

- If these rules do not establish an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.
- If you are covered under a right of continuation coverage pursuant to federal or state law (for example, COBRA continuation coverage), and you are also covered under another plan that covers you as an employee, member subscriber or retiree (or as that person's dependent), the latter plan is primary and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.

### IF YOU OR A DEPENDENT IS COVERED UNDER MEDICAID

If you or your dependent is a participant in the Plan and also covered under Medicaid, the Plan will pay before Medicaid. The Plan will not take the Medicaid coverage into account for purposes of enrollment or payment of benefits.

If, while you are covered under Medicaid, benefits are required to be paid by the Plan, but are first paid by the state plan, payment by the Plan will be made as required by any applicable state law which provides that payment will be made to the state.

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### IF YOU OR A DEPENDENT IS ELIGIBLE FOR OR ENROLLED IN MEDICARE

If you are enrolled in Medicare Part D, you are not eligible to enroll in the Associates' Medical Plan. Additionally, if your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical plan, but your dependent would not be eligible for such coverage.

In general, the Social Security Act requires that the Associates' Medical Plan be the primary payer if you or your dependent is eligible for or enrolled in Medicare Part A, or Parts A and B, and meet one of the following criteria:

- You are currently employed by the company and are age 65 or older
- You are currently employed by the company and your spouse/partner is age 65 or older
- You are an active participant or COBRA participant entitled to Medicare on the basis of end-stage renal disease, but only for the first 30-month period of eligibility for Medicare coverage (whether or not actually enrolled in Medicare throughout this period)
- You are under age 65 and are entitled to Medicare due to disability and are covered under the Plan due to being employed by the company, or
- Your dependent is under age 65 and is entitled to Medicare due to his or her disability and is covered under the Plan due to your being employed by the company.

The Plan will be secondary if you or your dependent is enrolled in Medicare and meets one of the following criteria:

- You or your dependent is a COBRA participant, except in the case of Medicare enrollment due to end-stage renal disease, for which the Plan is primary for the first 30-month period of eligibility for Medicare coverage, or
- You or your dependent is an active participant or COBRA participant enrolled in Medicare due to end-stage renal disease, after the 30-month coordination period with Medicare is exhausted.

### IF YOU ARE AGE 65 OR OLDER AND AN ACTIVE ASSOCIATE

If you are still working for the company, you may continue your coverage under the Associates' Medical Plan. If you also have Medicare, the Associates' Medical Plan will generally be primary and Medicare will be secondary. File your claim with the Associates' Medical Plan first.

You may also elect to end your coverage under the Associates' Medical Plan and choose Medicare as your primary coverage.

If you choose Medicare as your primary coverage, you may not elect this Plan as your secondary plan.

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### STATE-MANDATED AUTOMOBILE PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

If you reside in a state where automobile no-fault coverage, personal injury protection coverage or medical payment coverage is mandatory, that coverage is primary and the Plan takes secondary status. The Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

## If you go on a leave of absence

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



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**BREAK IN COVERAGE**

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status within one year from cancellation, you will be enrolled for the same coverage plans (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement. For more information, contact 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 coverage and your eligible dependents' coverage ends on your last day of employment, or when you are no longer eligible under the terms of the Plan. However, you may be able to continue your coverage under COBRA.

See the Eligibility and enrollment chapter for a complete list of events that may cause coverage to end. See the COBRA chapter for additional details regarding COBRA coverage.

## If you leave the company and are rehired

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). If your break is 30 days or less, the annual deductible, out-of-pocket maximum and HRA (if applicable) will not reset. If your break is greater than 30 days, your annual deductibles, out-of-pocket maximum and HRA (if applicable) will reset. If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically re-enrolled.

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

## If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar plans offered under the Plan). In this case, the annual deductible and waiting periods will not reset.

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

## Other information about the medical plan

**THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

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

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

Such coverage will be subject to the otherwise applicable annual deductibles and coinsurance/copayment provisions under the Plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For additional information, please call People Services at 800-421-1362.

**A NOTE ABOUT MATERNITY ADMISSIONS**

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

018939

# The pharmacy benefit

WHERE CAN I FIND?


| | |
|---|---|
| The pharmacy benefit | 86 |
| How the pharmacy benefit works | 86 |
| What is not covered by the pharmacy benefit | 89 |
| Pharmacy discounts for prescriptions not covered | 90 |
| Filing a pharmacy benefit claim | 90 |
| Privacy and security | 90 |


018939

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# The pharmacy benefit

**The pharmacy benefit is an important part of your benefits package. Prescription drugs play a critical role in treating illness and can help you and your eligible dependents maintain good health.**

PHARMACY BENEFIT RESOURCES

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

## What you need to know about the pharmacy benefit

- You are covered under the pharmacy benefit if you enroll in any of the medical plan options available under the Associates' Medical Plan. Associates enrolled in an HMO plan or the eComm PPO Plan receive pharmacy benefits through their medical plan.
- Except as noted in this chapter, associates must use a Walmart or Sam's Club pharmacy for pharmacy benefits to be paid. Benefits are generally not payable if you use another pharmacy.
- If your work location is more than five miles from a Walmart or Sam's Club pharmacy, associates who have medical coverage under the HRA High Plan, HRA Plan or HSA Plan have the option to have prescriptions filled at an Express Scripts network pharmacy, in addition to a Walmart or Sam's Club pharmacy.
- Under the Associates' Medical Plan, specialty drugs must be purchased from a Walmart Specialty Pharmacy or Accredo (the specialty pharmacy of Express Scripts).

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## The pharmacy benefit

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

To purchase prescriptions under your pharmacy benefit plan, simply present your plan ID card at a Walmart or Sam's Club pharmacy. If you are covered under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at any Express Scripts network retail pharmacy.

Under certain limited circumstances, as described below, associates can fill prescriptions at an Express Scripts network retail pharmacy even if your work location is within five miles of a Walmart or Sam's Club Pharmacy. When purchasing drugs by mail order, as described later in this chapter, you can use either Walmart or Express Scripts Mail Order.

No benefits will be paid if you use a non-network pharmacy. Visit WalmartOne.com to find information about:

- Walmart or Sam's Club pharmacies
- Retail pharmacies in the Express Scripts network
- Mail-order network pharmacies
- Covered generic, brand-name and specialty drugs, and
- Preventive medications.

You can also call Express Scripts at 800-887-6194.

### WHEN PRESCRIPTIONS CAN BE FILLED AT AN EXPRESS SCRIPTS NETWORK PHARMACY

If you have medical coverage under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you have the option of using an Express Scripts network pharmacy to fill your prescriptions, in addition to a Walmart or Sam's Club pharmacy, at the rates shown in the chart on the following page.

Associates may also have prescriptions filled at an Express Scripts network pharmacy regardless of their work location in certain limited circumstances, including the following:

- If a drug is out of stock and will not be available at a Walmart or Sam's Club pharmacy for an extended time (as defined by the Plan), you may transfer the prescription to an Express Scripts network pharmacy.
- If a covered drug is unavailable at a Walmart or Sam's Club pharmacy, it can be filled at an Express Scripts network pharmacy.
- If an emergency prescription fill is needed outside Walmart or Sam's Club store pharmacy hours, you may be able to fill your prescription at an Express Scripts network pharmacy.

**NOTE:** Certain restrictions apply to filling prescriptions for narcotics and other controlled substances.

For information on other exceptions and steps you must take, call Express Scripts at 800-887-6194.

## How the pharmacy benefit works

The pharmacy benefit covers only prescription drugs that are specifically listed on the closed formulary list maintained by Express Scripts. You can view an abbreviated list on the WIRE or at WalmartOne.com, or you may call Express Scripts at 800-887-6194 for a full list. If you don't see your drug listed, please call Express Scripts to see if it is on the formulary.

- If you are a participant in the HRA High Plan, the HRA Plan, any of the Accountable Care Plan options or the Select Network Plan, you purchase eligible prescriptions by paying the copays out of your own pocket. See the Pharmacy benefits chart on the next page for complete details about copays. (Money in your HRA account, if applicable to your medical coverage option, cannot be used to purchase prescriptions.) Your copays will be applied toward your medical plan's annual out-of-pocket maximum. Once your annual out-of-pocket maximum is met, eligible prescriptions will be paid at 100% for the remainder of the calendar year.
- If you are a participant in the HSA Plan, you pay the full retail/mail-order price for your prescriptions until you meet your medical plan's network annual deductible. Once you have met your network annual deductible, you pay the copays listed in the Pharmacy benefits chart. (The exceptions are medications on the Express Scripts list of approved preventive medications, which are not subject to the HSA Plan's network annual deductible. See Preventive medications not subject to the HSA Plan's network annual deductible later in this chapter for details.) Your copays will be applied toward your medical plan's annual out-of-pocket maximum. Once your annual out-of-pocket maximum is met, eligible prescriptions will be paid at 100% for the remainder of the calendar year.

Under its agreement with Express Scripts, the Plan has negotiated discounted prices on generic and brand-name drugs that are available when eligible prescriptions are filled at retail and mail-order network pharmacies. If, at the time your prescription is filled, the discounted price available is lower than the copay, you will be charged the lower amount, which may include a dispensing fee. Participants in the HSA Plan pay the full retail/mail-order price for most prescriptions until the medical plan's network annual deductible is met.

Refer to the Pharmacy benefits chart on the next page for details about copays and coinsurance.



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PHARMACY BENEFITS

| | | |
|---|---|---|
| **Generic drugs**<br>Up to 30-day supply<br>31- to 60-day supply<br>61- to 90-day supply | <br>$4 copay<br>$8 copay<br>$12 copay | **Filling your prescriptions**<br>• *Simply present your plan ID card at a Walmart or Sam's Club pharmacy.*<br>• *If you are covered under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than 5 miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at an Express Scripts network retail pharmacy.*<br>• *See When prescriptions can be filled at an Express Scripts network pharmacy on the previous page for additional information.* |
| **Brand-name drugs** | Greater of $50 or 25% of allowed cost | |
| **Specialty drugs**<br>*Available only at Walmart Specialty Pharmacy or ESI/Accredo* | Greater of $50 or 20% of allowed cost | |

**Under the HSA Plan:** The charges listed above apply after the HSA Plan's network annual deductible has been met, with the exception of medications that are on the Express Scripts list of approved preventive medications, which are not subject to the deductible. See Preventive medications not subject to the HSA Plan's network annual deductible later in this chapter for details.

**Mail-order drugs:**

- Your cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above.
- For brand-name drugs, 31-day supplies or greater must be purchased through mail order, through Walmart or Express Scripts mail order.

## TYPES OF DRUGS

To be covered under the Plan, prescription drugs must be on the Plan's formulary, which is a list of generic and brand-name medications covered by the Plan. The formulary includes medications that have been tested for quality and effectiveness and are believed to be a necessary part of a quality treatment program. The formulary is reviewed quarterly and can change. You can view an abbreviated list on the WIRE or at WalmartOne.com, or you may call Express Scripts at 800-887-6194 for a full list.

Note that the Plan has a closed formulary. This means that your prescription drugs, whether they fall under the generic, brand-name or specialty drug category, must be included on the Plan's formulary for pharmacy benefits to be paid under the Plan.

**Generic drug:** When a brand-name drug's patent expires, a generic equivalent of the drug may become available. When a generic equivalent becomes available, the brand-name drug will no longer be covered. Generic equivalents work like the brand-name drug in dosage, strength, performance and use, and must meet the same quality and safety standards. All generic drugs must be reviewed by the United States Food and Drug Administration (FDA). For more information, visit WalmartOne.com.

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IMPORTANT NOTES ABOUT YOUR PRESCRIPTION DRUG BENEFITS LISTED IN THE CHART ABOVE

- Refills of retail prescriptions are available after 75% of your previous prescription for the same drug has been used.
- Certain eligible preventive over-the-counter medications are fully covered if prescribed by a physician. See Preventive over-the-counter medications later in this section.
- If you are eligible for and choose to enroll in an HMO or the eComm PPO Plan, you will receive your prescription drug benefits through your medical plan.
- Prescription drug copays and coinsurance charges count toward your medical plan's annual out-of-pocket maximum. If you have coverage under the HSA Plan, eligible pharmacy charges you pay before you meet your network annual deductible also count toward the HSA Plan's annual out-of-pocket maximum. Once you meet the out-of-pocket maximum applicable to your coverage, eligible prescription drug charges are paid at 100% for the remainder of the calendar year.
- Discounts, coupons, pharmacy discount programs or similar arrangements 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) will not count toward the medical plan's annual out-of-pocket maximum. In addition, if you have coverage under the HSA Plan, such charges will not count toward the HSA Plan's network annual deductible.

**Brand-name drug:** A covered brand-name drug is a drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared to similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

**Specialty drug:** Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they are administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. (Medications used to treat diabetes are not considered specialty medications.)

## MAIL-ORDER PRESCRIPTIONS

Mail-order prescriptions can save you a trip to the pharmacy and provide the convenience of prescription drugs delivered to your home. Mail-order prescriptions can be purchased through Walmart or Express Scripts mail order (under any of the Associates' Medical Plan coverage options). If you have a chronic condition, such as diabetes or asthma, and require the same or similar prescriptions throughout the year, you may want to consider the mail-order option for your pharmacy needs. Your mail-order cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy. For brand-name drugs, 31-day supplies or greater must be purchased through mail order only, through Walmart or Express Scripts mail order. Contact your Walmart or Sam's Club pharmacy or Express Scripts, or call People Services at 800-421-1362 for additional information regarding the mail-order prescription service.

## CONTRACEPTIVES FOR WOMEN

The Plan covers all FDA-approved contraceptive methods, including approved over-the-counter (OTC) variations for women, as required by the Affordable Care Act. Contraception has additional health benefits such as reduced risk of cancer and protection against osteoporosis. Under the terms of the Affordable Care Act, all generic contraceptives (and brand-name contraceptives when medically necessary) will be covered at 100%, when prescribed by a physician. If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug. See Filing a pharmacy benefit claim at the end of this chapter.

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

Certain preventive medications will be covered under the HSA Plan before the Plan's network annual deductible is satisfied. Prescription drugs that can keep you from developing a health condition are called "preventive medications." These drugs can help you maintain your quality of life and avoid expensive treatment, helping to reduce your overall health care costs. If you are taking prescribed drugs for certain health issues, such as high blood pressure, high cholesterol, etc., you may be eligible to get these medications before your HSA Plan's network annual deductible is satisfied. Eligible medications will be allowed at the applicable copays listed in the Pharmacy benefits chart on the previous page. A list of these medications can be found on the WIRE or WalmartOne.com.

## PREVENTIVE OVER-THE-COUNTER MEDICATIONS

If you are enrolled in the Associates' Medical Plan, costs of certain generic OTC medications are covered at 100% when they are prescribed by a physician and you purchase them at retail network pharmacies. Covered OTC preventive care medications are those required by regulations issued under the Affordable Care Act. (Please note that the Plan's coverage of OTC preventive care medications may change as additional regulations are issued.) For the covered generic OTC medications to be paid at 100% by the pharmacy benefit plan, you must purchase them at one of the retail network pharmacies and present your plan ID card and a prescription from your physician at the time of purchase. The Plan covers preventive generic medications at 100%. If your physician believes a brand-name preventive OTC medication is medically necessary, the physician can file an appeal directly with Express Scripts for coverage of the brand-name drug, or you may file a claim for the brand-name drug under the procedures listed in the Filing a pharmacy benefit claim section of this chapter.

Some of the most common preventive OTC medications identified by the United States Preventive Services Task Force (USPSTF) are listed in the chart below. For the most up-to-date list of covered preventive care OTC medications, go to the WIRE or WalmartOne.com or call Express Scripts at 800-887-6194.

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| PREVENTIVE OVER-THE-COUNTER MEDICATIONS Recommended by the U.S. Preventive Services Task Force (USPSTF) | |
|---|---|
| Oral fluoride | By prescription when appropriate for children 6 months to 6 years of age |
| Folic acid | By prescription for all women planning or capable of pregnancy |
| Generic aspirin | By prescription for adults age 45 to 59 who have 10% or greater 10-year cardiovascular disease risk, are not at increased risk for bleeding, have life expectancy of at least 10 years and are willing to take low-dose aspirin for at least 10 years; low-dose aspirin (81mg/d) by prescription after 12 weeks of gestation in pregnant women at high risk for preeclampsia |
| Vitamin D | By prescription for individuals age 65 and over |
| Generic statin | By prescription for adults age 40 to 75 with no history of cardiovascular disease, 1 or more risk factors and a calculated 10-year CVD event risk of 10% or greater |
| Bowel prep agents | By prescription when appropriate for a preventive colonoscopy for adults over age 50 |

### MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required for some medications in order for them to be covered by the Plan. Express Scripts, the Plan Administrator, may ask your physician to provide additional information, which is considered "a coverage authorization."

After receiving the required information, Express Scripts will notify you and your doctor (usually within two business days) to confirm whether or not coverage has been authorized. If it is determined that the prescription is not a covered benefit under your pharmacy plan, it will not be paid. You may appeal this decision, as described in the Claims and appeals chapter. If you elect to fill the prescription without prior authorization, you will be responsible for the full retail cost.

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

### MEDICATIONS WITH QUANTITY LIMITS

Certain medications have limits on the quantity you can receive per prescription. These limits are based upon the approved FDA dosage guidelines for the medication. A list of these medications can be found on the WIRE or WalmartOne.com.

Prescriptions written for no more than the designated quantity of the drug will be processed by your pharmacy benefit plan at the appropriate copay. Prescriptions for quantities greater than the FDA-approved quantity will not be processed by your pharmacy benefit plan, and you will be responsible for 100% of the cost.

### THE CASTLIGHT TOOL AND PRESCRIPTION DRUGS

Castlight, the personalized tool that lets you make price and quality-of-care comparisons of medical providers based on user reviews, can also be a useful tool for learning about prescription drugs. With Castlight you can compare prices of prescription drugs, track your out-of-pocket costs, compare generics and brand-name drugs, get personalized alerts based on your past prescriptions and access extensive educational resources. See the Castlight section in The medical plan chapter for information on getting started with Castlight.

## What is not covered by the pharmacy benefit

Medications or services not covered by the pharmacy benefit include but are not limited to the following:

- Compound medications: Drugs that consist of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order. Compound drugs include ingredients that are either over-the-counter or are not approved by the FDA and as such are not covered by the Plan.
- Over-the-counter drugs (with the exception of insulin, when a state does not require a prescription for it, and those covered as part of the preventive care benefit under the Affordable Care Act, when a prescription is provided).
- Prescriptions filled at a pharmacy other than a Walmart or Sam's Club pharmacy (except as noted in this chapter).
- Prescriptions filled by non-network pharmacies for your particular medical plan option.
- Prescription drugs with available over-the-counter equivalents.
- Prescription drugs purchased through a pharmacy discount program.
- Drugs for which prior authorization has not been secured, in cases where prior authorization is required under the Plan.

The above list is not meant to be a comprehensive or all-inclusive list of excluded benefits. For questions about excluded benefits, call Express Scripts at 800-887-6194.

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## Pharmacy discounts for prescriptions not covered

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

To use the retail pharmacy discount, present your medical plan ID card to the pharmacy when you pick up your prescription. If the prescription is covered by the pharmacy benefit, the corresponding copay will apply. If the prescription is not covered by the pharmacy benefit, the retail pharmacy will automatically discount the cost of the drug. If the prescription is covered under the Associates' Medical Plan but is being filled too soon, is prescribed for off-label use or does not follow other similar Plan terms, the prescription will not be covered by the pharmacy benefit and the retail pharmacy discount will not apply. For more information, contact Express Scripts at **800-887-6194**.

## Filing a pharmacy benefit claim

When you fill a prescription at an eligible network pharmacy, including a mail-order pharmacy, you do not need to file a claim. However, if you are unable to use your card at a network pharmacy or if you disagree with the amount you paid, you may file a claim with Express Scripts. Your claim must be submitted in writing within 18 months of the date you had the prescription filled (or you attempted to have it filled). If the prescription is an eligible prescription under the Plan, it will be paid in accordance with Plan terms.

Please call Express Scripts at **800-887-6194** to obtain a claim form, or visit the **WIRE** or **WalmartOne.com**. Your claim will be processed according to the terms described in the **Claims and appeals** chapter.

If your claim is denied, you have a right to appeal the denied claim. If you file an appeal, it will be processed according to the terms described in the **Claims and appeals** chapter.

### COORDINATION OF BENEFITS

The pharmacy plan does not coordinate benefits for prescription drug claims. If any portion of a prescription drug claim is reduced, subsidized or paid by another health plan, insurance provider or pharmacy discount program, the Plan will not pay any amount of the pharmacy benefit claim.

## Privacy and security

When you purchase prescription drugs through a Walmart or Sam's Club pharmacy or an Express Scripts network pharmacy, you can rest assured that your personal and medical information is kept confidential. All pharmacies that participate in the pharmacy network are covered by and adhere to applicable state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protects the privacy of personal health information. Walmart values the trust that our associates place in us. Earning that trust is in accordance with our core value of respect for the individual. For more information, see **Notice of privacy practices — HIPAA information** in the **Legal information** chapter.

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# Health Savings Account

## WHERE CAN I FIND?


| | |
|---|---|
| Health Savings Account advantages: tax breaks and Walmart contributions | 94 |
| Health Savings Account eligibility | 94 |
| Opening your Health Savings Account | 95 |
| Contributions to your Health Savings Account | 96 |
| Paying qualified medical expenses through your Health Savings Account | 98 |
| Investing your Health Savings Account | 98 |
| If you leave the company or are no longer enrolled in the HSA Plan | 98 |
| Closing your Health Savings Account | 98 |


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# Health Savings Account for HSA Plan participants

**The Health Savings Account offers HSA Plan participants real savings on qualified health care expenses. Once you open your account, Walmart matches your tax-free contributions dollar-for-dollar, up to set limits. Depending on the level of coverage you choose, Walmart matches up to $350 for individual coverage and up to $700 for family coverage. Your account balance earnings are tax-free and, as the money grows from year to year, you can use it to pay for current or future medical expenses on a tax-free basis.**

HEALTH SAVINGS ACCOUNT RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Establish an account or change your contribution amount | Log on to the WIRE, WalmartOne.com or Workday | Call People Services at 800-421-1362 |
| Access your Health Savings Account | Log on to MyHealthEquity.com<br>If you are logging in for the first time as a member and have not already established a user ID and password, please click the "Begin Now" button. | Call HealthEquity at 866-296-2860<br>HealthEquity is the HSA administrator and custodian. |
| Get a list of qualified medical expenses (I.R.C.§ 213(d))<br>Get information on contribution limits, eligibility and tax reporting responsibilities associated with a Health Savings Account | irs.gov | Call HealthEquity at 866-296-2860 or contact your tax advisor |

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## What you need to know about the Health Savings Account

- You must be enrolled in the HSA Plan in order to open and contribute to a Health Savings Account.
- Walmart will match on a pretax basis each dollar you contribute, up to the matching limit, if you open your Health Savings Account by December 1 of the Plan year.
- The Health Savings Account allows you to pay for IRS-determined qualified medical expenses with tax-free dollars.
- During your enrollment session, you may accept the terms and conditions of the Health Savings Account; the account will not be considered "open," however, until you have successfully passed the customer identification process. If additional documentation is required to complete this process, HealthEquity will contact you directly. In no event will your account be considered open prior to the effective date of your HSA Plan coverage.
- No payroll withholding or employer contributions will be deposited to your Health Savings Account until it is open.
- A welcome kit will be mailed to your home address from HealthEquity within two weeks of your HSA Plan effective date if you have taken the necessary steps to open your account.
- 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, which provides health benefit coverage for Walmart associates traveling internationally on business. You are encouraged to consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

## Health Savings Account advantages: tax breaks and Walmart contributions

The Health Savings Account offers HSA Plan participants:

- Walmart contributions: Walmart matches your pretax contributions dollar-for-dollar, up to the matching limit.
- The ability to contribute pretax dollars to the account through payroll deductions.
- The ability to pay for qualified medical expenses with tax-free dollars through the account, including easy access to the money in your account using the debit card you will receive. You can also access the funds in your account by logging in to MyHealthEquity.com. However, if the funds are used for nonmedical or nonqualified medical expenses, income tax will apply and a 20% penalty may also apply. Note that over-the-counter drugs are considered qualified medical expenses, eligible for tax-free reimbursement under a Health Savings Account, only if they are prescribed by a doctor. (This requirement does not apply to insulin.)

HealthEquity is the HSA administrator/custodian with which Walmart has contracted to receive Health Savings Account contributions from Walmart's payroll. In order to receive the Walmart contribution to your Health Savings Account or make pretax contributions through payroll deduction, you must maintain an open account with HealthEquity and continue medical coverage through the HSA Plan. If you have a Health Savings Account with another custodian, Walmart will not provide the Walmart contribution to your account or allow you to make pretax contributions through payroll deduction for that Health Savings Account, even if Walmart contracted with that custodian in the past.

Interest earnings and capital gains on the balance in your account will not be taxed during the period in which the funds remain in your account. In addition, all Health Savings Account funds withdrawn for qualified medical expenses are tax-free.

You have investment opportunities for your account balance once that balance reaches a certain amount. Investments are not guaranteed or FDIC-insured.

The balance in your Health Savings Account rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through your custodian or spend it on qualified medical expenses.

**NOTE:** State tax law may differ from federal tax law in certain states, including Alabama, California and New Jersey.

Please consult your tax advisor or HealthEquity if you have questions about either the federal or state tax implications of a Health Savings Account.

## Health Savings Account eligibility

As an HSA Plan participant, you are eligible to open a Health Savings Account as long as you are not enrolled in other health coverage, as described below. Please see the Opening your Health Savings Account section of this chapter. Even if you are enrolled in the HSA Plan, you are not eligible for the Health Savings Account if you:

- Are covered under any other health plan that is not a qualified high-deductible health plan, including a health care flexible spending account (exceptions include some disease-specific coverage; dental, vision, long-term care and disability coverage; accident policies such as critical illness insurance and accident insurance, and others)
- Are enrolled in Medicare
- Are enrolled in Medicaid
- Are covered under TRICARE®
- Have received medical benefits from the U.S. Department of Veterans Affairs during the preceding three months, other than benefits for preventive care or a service-connected disability, as defined by applicable law (mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to a Health Savings Account), or
- Are claimed as a dependent on another person's tax return.

If you are an HSA Plan participant and also enrolled in critical illness insurance, you're not eligible for the major organ transplant rider under that coverage due to IRS guidance suggesting that such coverage would be viewed as non-high-deductible plan coverage.

Other restrictions may apply. For further information, please call HealthEquity at 866-296-2860.

During the Plan year, you may be required to confirm account eligibility to continue contributions (for example, if you become Medicare-eligible because of your age, you may be asked to verify that you have not enrolled in Medicare).

The HSA Plan is a qualified high-deductible health plan (HDHP) subject to ERISA and to requirements of federal law that allow you to contribute to a Health Savings Account. However, Walmart intends for the Health Savings Account to be exempt from ERISA by complying with the terms of the Department of Labor Field Assistance Bulletins No. 2004-1 and 2006-02. Accordingly, the Health Savings Account is not established or administered by Walmart or the Associates' Health and Welfare Plan. Instead, the Health Savings Account is established by the associate during the enrollment process and administered by HealthEquity.

If you have non-high-deductible health plan coverage through Walmart or any other employer (e.g., your eligible spouse/partner's employer), including a Flexible Spending Account (FSA) or a Health Reimbursement Account



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(HRA), you are generally ineligible to make Health Savings Account contributions (but you can enroll in the HSA Plan). There are exceptions to this rule for "limited purpose" FSAs/HRAs, which can be used only for dental or vision coverage, or for "post-deductible" FSAs/HRAs, which provide coverage only after you satisfy the deductible under an HDHP. For additional information, please contact HealthEquity by phone at 866-296-2860 or online at MyHealthEquity.com.

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 Plan, which provides health benefit coverage for Walmart associates traveling internationally on business. Consult your tax advisor for information on appropriate steps for adjusting your personal contributions to a Health Savings Account with respect to the GeoBlue benefit.

## Opening your Health Savings Account

When you enroll online in the HSA Plan through the WIRE, WalmartOne.com or Workday, you will choose the amount you want to contribute to your account through payroll deductions. You may change your contribution amount at any time. See Opening and changing contribution amount later in this chapter.

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You'll receive a welcome kit at your home address directly from HealthEquity, the Health Savings Account custodian, generally within the following time frames:

- By the end of December if you enroll during annual enrollment, or
- Within two to three weeks after your Health Savings Account is opened if you enroll at any other time.

Your debit card will be included within the welcome kit. You can activate your debit card online at MyHealthEquity.com or by calling HealthEquity at 866-296-2860.

No payroll withholding or employer contributions will be deposited to your Health Savings Account until it is open. Your account will not be considered "open" until you have successfully passed the customer identification process required to open an HSA. If additional documentation is required to complete this process, HealthEquity will contact you directly.

In the event that any payroll withholding or employer contribution is made prior to your account being opened, the contribution will be held by your custodian and deposited into your Health Savings Account once your account has been opened. If your account is not opened within a reasonable amount of time, as determined by your custodian, the funds withheld from your check will be refunded to you through your payroll check (less any applicable payroll taxes) and reported as wages on your Form W-2, and the employer contribution, if any, will be returned to Walmart.

For questions about your account status or fulfillment (welcome kit or debit card), you may call HealthEquity at 866-296-2860 or go online to MyHealthEquity.com.

Once Walmart receives confirmation from HealthEquity that your account has been opened and you have completed your Health Savings Account deductions selection online, your payroll deduction contributions to the account and Walmart's matching contributions will begin the following pay period. See When company contributions are made later in this chapter.

If you do not open your Health Savings Account by December 1 of the Plan year, you will forfeit your right to the company's contributions for that year, even if you are covered by the HSA Plan during that year or a portion of that year.

For the purposes of company funding and payroll deductions, you are required to select HealthEquity as your Health Savings Account custodian when you enroll. However, you may move your funds to another Health Savings Account custodian at any time. If you move your Health Savings Account funds to a bank other than HealthEquity and do not maintain a Health Savings Account with HealthEquity, pretax payroll deductions will not be available, you will not receive the company matching contributions and all Health Savings Account fees will be your responsibility.

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### HEALTH SAVINGS ACCOUNT FEES

The company will pay the monthly maintenance fees if you are enrolled in the HSA Plan and your Health Savings Account custodian is HealthEquity.

The company will not pay overdraft fees, excess contribution fees or lost card fees. If you are enrolled in COBRA, terminate employment with the company, otherwise become ineligible for coverage under the Associates' Medical Plan or are no longer enrolled in the HSA Plan, all associated fees will become your responsibility. These fees will be deducted automatically from your Health Savings Account balance if any of these events occur. You may call HealthEquity at 866-296-2860 to learn more about the fees for various Health Savings Account services. It is your responsibility to check your Health Savings Account balance prior to using funds to pay for services. Current rate and fee schedules are available online at MyHealthEquity.com. The fee schedule is also included in the welcome kit.

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## Contributions to your Health Savings Account

Once you have opened your Health Savings Account, as long as your account remains open and you are enrolled in the HSA Plan, Walmart may make contributions to your account as follows:

- Walmart matches your pretax contributions dollar-for-dollar, up to the matching limit described in the chart below.
- You may make pretax contributions to the account through payroll deductions in any amount (of $5 or more each pay period) up to the legal limit (taking into account Walmart's contributions). For administrative purposes, contributions will generally be based annually on 25 pay periods.
- You can make personal contributions to your account by mailing a check or by electronic funds transfer (EFT) once you have linked a personal bank account on the HealthEquity website. These contributions will be made on an after-tax basis and are not eligible for the Walmart matching contribution. Walmart does not track after-tax contributions to the account and you would therefore need to count such contributions against your annual contribution limit. Check with your tax advisor to determine if you can deduct them from your federal or state tax return.
- In the event your requested Health Savings Account contribution for a specific pay period exceeds the amount of your paycheck after deductions, no contribution or company match will be made to your Health Savings Account for that pay period.
- With respect to your final paycheck, your Health Savings Account salary reductions and corresponding employer match may be reduced because of state law restrictions on salary reduction or because your requested Health Savings Account contribution exceeds the net amount of your payroll check after deductions.

If you experience a status change event and switch from associate-only coverage to family coverage under the HSA Plan during the year, Walmart will increase its matching contribution to correspond with the matching contribution limit for family coverage. If you experience a status change event and switch from family coverage to associate-only coverage during the year, the matching contributions that the company made prior to the change will not be reduced. In the event this results in your having contributions in your account above the annual maximum contribution allowed under IRS guidelines, the excess contributions will need to be withdrawn by your tax-filing deadline to avoid additional taxes.

Associates who are actively enrolled in the HSA Plan are eligible for matching contributions to the specified limit only for contributions made through payroll deductions.

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

### ANNUAL CONTRIBUTION LIMITS

By law, the maximum annual contribution that can be made to your account, including both the company's contributions and your contributions (pretax and after-tax), is:

- For 2018, $3,450 for individual coverage, or
- For 2018, $6,900 for family coverage.

The annual maximum contribution is the total contribution from all sources (payroll contributions by the associate and/or the company and personal contributions) to all accounts.

These amounts are indexed annually by the federal government and are subject to change each year. Please contact your Health Savings Account custodian for questions regarding the contribution limits. If you are age 55 or older, see the section **If you are age 55 or older** later in this chapter for special contribution rules.

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

| Your HSA Plan network annual deductible | Company matching contribution limit: $1 for $1 up to | Maximum annual contribution limit (associate and company contributions combined) |
|---|---|---|
| $3,000 (associate-only coverage) | $350 | $3,450 |
| $6,000 (family coverage) | $700 | $6,900 |

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If two associates who are legally married are both eligible to contribute to individual Health Savings Accounts, the contribution limit for 2018 for both accounts combined is based on the maximum amount that can be contributed for a family: $6,900. Note, however, if either of the associates is age 55 or older in 2018, the total combined contribution is increased by $1,000 for each associate age 55 or older.

If two associates are in a relationship described under the definition of "eligible dependent," but this relationship is other than a legal marriage, and they have family coverage, each associate is eligible to contribute to an individual Health Savings Account up to the maximum family contribution limit of $6,900 (provided that neither associate can be claimed as a tax dependent on any individual's federal tax return). If either associate is age 55 or older in 2018, the maximum contribution is increased by $1,000 for each associate.

It's important to monitor contributions to your Health Savings Account — there will be adverse tax consequences if your contributions exceed the annual limit that has been set by the federal government. Changes in coverage during the year or enrollment after the beginning of the year can affect your contribution limits. If you become aware during the year that combined contributions to your Health Savings Account exceed the annual limit, you can withdraw the excess contribution and the related interest earnings before your income tax return for the year is due (including extensions). For assistance and information, call HealthEquity at 866-296-2860.

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## EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT

The balance in your Health Savings Account earns interest. For interest rate information on your account, contact HealthEquity at 866-296-2860 or go online to MyHealthEquity.com. Your current interest earned along with the interest rate schedule is available on your monthly statements.

## WHEN COMPANY CONTRIBUTIONS ARE MADE

The company will match dollar-for-dollar the amount that you contribute through payroll deductions each pay period, up to the matching limit for your coverage, as shown in the chart titled Your contributions and the company's contributions to the Health Savings Account. The company will deposit this contribution, along with any contribution you make through payroll deduction, into your Health Savings Account shortly after the payroll deduction period ends. Walmart will initiate authorized payroll deductions once your Health Savings Account custodian confirms that your Health Savings Account is open and you complete your payroll deduction selection online.

## SETTING UP OR CHANGING YOUR CONTRIBUTION AMOUNT

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

To set up your initial contribution amount or to change your contribution amount at any time, log on to the WIRE, WalmartOne.com or Workday and click on "Online Enrollment." If you need help setting up your payroll deductions, please contact People Services at 800-421-1362.

**NOTE:** Once you make the maximum annual contribution (as stated in the chart on the previous page), your payroll contributions will automatically cease. It will be your responsibility to make a new contribution decision at the next annual enrollment for the following calendar year.

## IF YOU ARE AGE 55 OR OLDER

If you are age 55 or older, you can make additional contributions to your Health Savings Account. These are called catch-up contributions and can be made by payroll deductions just like your normal contribution. For 2018, the catch-up contribution limit is $1,000. Please call HealthEquity at 866-296-2860 for information on catch-up contributions.

If you also cover your spouse under the HSA Plan and your spouse is age 55 or older, he or she may also be eligible to open a second Health Savings Account and contribute catch-up contributions. The contribution limit for 2018 for both accounts combined is based on the maximum amount that can be contributed for a family: $6,900. If either you or your spouse is age 55 or older in 2018, the total combined contribution is increased by $1,000 for each participant age 55 or older. The company will not contribute funds or pay any fees associated with the Health Savings Account for your spouse.

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If you cover an eligible partner under the HSA Plan and that individual is other than a spouse, you and your partner are each eligible to contribute to individual Health Savings Accounts up to the maximum family contribution limit of $6,900 (provided that neither party can be claimed as a tax dependent on any individual's federal tax return). If either associate or partner is age 55 or older in 2018, the maximum contribution is increased by $1,000 for each participant age 55 or older. The company will not contribute funds or pay any fees associated with the Health Savings Account for your partner.

Please call HealthEquity at 866-296-2860 for information on how to open a Health Savings Account for your eligible spouse/partner.

## Paying qualified medical expenses through your Health Savings Account

While the funds in your Health Savings Account belong to you, any money not used for qualified medical expenses will be subject to federal income tax as well as a 20% penalty if you are under the age of 65. You will be required to report the distribution and any applicable penalty on your federal tax return and possibly your state tax return. Qualified medical expenses must be incurred by you, your spouse or your children who qualify as tax dependents. Expenses incurred by any other individual (e.g., your partner) are not considered qualified medical expenses, unless your partner qualifies as your tax dependent. Qualified medical expenses generally include medical, dental and vision expenses, chiropractic care and acupuncture. Note that amounts paid for over-the-counter drugs are considered qualified expenses only if the drugs are prescribed by a doctor. (This requirement does not apply to insulin.) Please visit WalmartOne.com or MyHealthEquity.com to view examples of items generally considered to be medical expenses under Internal Revenue Code section 213(d). If you have questions about qualified medical expenses, please contact HealthEquity.

### FILING YOUR INCOME TAX RETURN

Each January, you will receive tax forms to report distributions, contributions and the market value of your Health Savings Account for the previous calendar year. IRS Form 1099-SA reports the distributions from your Health Savings Account in the previous calendar year. IRS Form 5498-SA reports the contributions to your Health Savings Account either "in" or "for" the previous calendar year and the fair market value of your account as of December 31. Both forms are also viewable online. You should save all of your medical expense receipts for income tax purposes. Under IRS guidelines, you must file an IRS Form 8889 with your federal tax return if you (or someone on your behalf, including your employer) make contributions to a Health Savings Account during the year. IRS Form 8889 must also be filed if you have a Health Savings Account balance or use Health Savings Account funds during the year, even if you do not make contributions to the Health Savings Account in that year. Please consult your tax advisor if you have questions regarding the tax forms mentioned above.

## Investing your Health Savings Account

Once your account has reached a minimum balance of $1,000, any amount over that balance can be invested in the selected mutual funds. Over 20 investment funds are available. You can review the funds and learn more online at MyHealthEquity.com under "Investments."

## If you leave the company or are no longer enrolled in the HSA Plan

The funds in your Health Savings Account belong to you as the account holder, even if you enroll in COBRA, change plans (and are no longer enrolled in the HSA Plan), change jobs or leave the company. In these events, all fees associated with the account will become your responsibility.

## Closing your Health Savings Account

All funds in your Health Savings Account belong to you, and you may use these funds for qualified medical expenses on a tax-free basis. If you choose to no longer maintain the account, it is your responsibility to close your account (for example, if you are no longer enrolled in the HSA Plan). Call HealthEquity at 866-296-2860 for information on how to close your account.

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# The dental plan

## WHERE CAN I FIND?


| | |
|---|---|
| Your dental plan | 102 |
| How the dental plan works | 102 |
| Filing a dental claim | 103 |
| What is covered under the dental plan | 104 |
| Limited benefits | 106 |
| What is not covered under the dental plan | 106 |
| If you go on a leave of absence | 107 |
| When dental coverage ends | 107 |
| If you leave the company and are rehired | 107 |
| If you drop coverage and re-enroll | 107 |


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# The dental plan

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

DENTAL PLAN RESOURCES

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

## What you need to know about the dental plan

- Dental plan coverage is available to all hourly and management associates and their eligible dependents (except for the spouses/partners of part-time associates, temporary associates and part-time truck drivers).
- Dental plan coverage must remain in effect for two full calendar years.
- Orthodontia assistance is covered after a 12-month waiting period.
- Once you meet the annual deductible, the Plan pays benefits of up to $2,500 per covered person per calendar year and a lifetime maximum orthodontia benefit of $1,500 per covered person. The annual deductible does not apply for preventive or orthodontic services.
- Claims may be reviewed by dental consultants to help ensure that the treatment provided meets the guidelines of the dental plan.
- If you have medical coverage with the Associates' Medical Plan, both the dental and medical information are on your plan ID card. Your plan ID card will be mailed to your home address. If you are enrolled in an HMO or if you have dental-only coverage, you will receive a Delta Dental ID card. Your Delta Dental ID card will be mailed to your home address.

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## Your dental plan

Walmart offers the dental plan to help eligible associates pay for routine dental care. The dental plan is administered through Delta Dental.

Please note that once you enroll in the dental plan, your coverage must remain in effect for two full calendar years. For example, if you enroll on July 1, 2018, your coverage must remain in effect until December 31, 2020. You can add or remove an eligible dependent during annual enrollment or due to a status change event (see the Eligibility and enrollment chapter). However, you must maintain a minimum of associate-only coverage for two full calendar years.

When you enroll in the dental plan, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates or part-time truck drivers).

For information on dependent eligibility and when dependents can be enrolled, see the Eligibility and enrollment chapter.

The dental plan benefit is self-insured. This means there is no insurance company that collects premiums and pays benefits. Instead, participating associates make contributions to cover the cost of their benefits. Claims are processed by Delta Dental of Arkansas.

## How the dental plan works

The dental plan covers four types of dental services:

- **Preventive and diagnostic care:** You do not have to meet the annual deductible ($75 per person/$225 maximum deductible per family) before benefits for preventive and diagnostic care begin. However, charges you incur for preventive and diagnostic care will not apply toward your annual deductible.
- **Basic care** includes fillings, non-surgical periodontics and root canal therapy and is covered after you meet the annual deductible.
- **Coverage for major care**, which includes surgical periodontics, crowns and dentures, begins after you have met the annual deductible.
- **Orthodontia assistance** coverage begins after you have participated in the dental plan for 12 months; you do not have to meet the annual deductible before receiving benefits for orthodontia care. However, charges you incur for orthodontia care will not apply toward your annual deductible.

**NOTE:** The 12-month waiting period for orthodontia assistance is waived for localized associates and their covered dependents.

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COVERAGE UNDER THE DENTAL PLAN
Including dental plan benefits that apply to your annual deductible or lifetime maximum

| | | | |
|---|---|---|---|
| **Annual deductible**<br>Waived for preventive and diagnostic care and orthodontia care | $75 per person/$225 maximum per family | | |
| **Maximum benefits**<br>Does not apply to orthodontia care | $2,500 per covered person per calendar year | | |
| | Delta Dental PPO dentists | Delta Dental Premier dentists | Non-network dentists |
| **Preventive and diagnostic care**<br>Charges (if any) do not count toward annual deductible | 100% covered; no annual deductible applies | 80% covered;* no annual deductible applies | 80% covered; no annual deductible |
| | *In areas served by an insufficient number of PPO dentists, as determined by facility location, services will be covered at 100%. Go to the WIRE or WalmartOne.com for details. | | |
| **Basic care**<br>Including fillings, non-surgical periodontics and root canal therapy | 80% of maximum plan allowance after annual deductible is met (70% of maximum plan allowance for composite resin fillings in posterior teeth) | | |
| **Major care**<br>Including surgical periodontics, crowns and dentures | 50% of maximum plan allowance after annual deductible is met | | |
| **Orthodontia assistance (12-month wait)**<br>Charges do not count toward annual deductible | 80% of maximum plan allowance up to $1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies | | |



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After you have met the annual deductible (if applicable for the service you received) and completed any applicable waiting periods, the Plan pays a percentage of the maximum plan allowance (MPA) for covered expenses.

### MAXIMUM PLAN ALLOWANCE

The maximum plan allowance applies to both covered in-network and covered out-of-network dental services. The MPA is the maximum amount the Plan will cover or pay for dental services covered by the Plan.

For covered in-network services, the MPA is that portion of a provider's charges covered by the Plan as determined by the provider's contract with Delta Dental of Arkansas (which includes contracts with an independent licensee company of the Delta Dental Plans Association). Network providers contracted with Delta Dental agree to accept an amount negotiated by Delta Dental of Arkansas for covered services as payment in full, subject to the annual deductible and coinsurance amounts applicable to your coverage.

For covered out-of-network services, the MPA is limited to the allowance set by Delta Dental of Arkansas in its discretion and utilizing such methods or benchmarks Delta Dental may choose to employ, which may include the pricing or allowance offered by the Delta Dental plan in the state where the services were provided. If you see a dental provider who is not contracted with Delta Dental, the Plan will pay the lesser of the MPA or the provider's actual billed charges for a covered procedure. If the provider's billed charges exceed the Plan's MPA, you are responsible for paying your provider the difference. For additional information, call Delta Dental at 800-462-5410.

### KNOW WHAT YOU'LL OWE: GET A PRETREATMENT ESTIMATE

You can find out how much the dental plan will pay for a procedure before the dental work is done by having your dentist submit a proposed treatment plan to Delta Dental. It is recommended that a proposed treatment plan be submitted for treatment totaling $800.00 or more, particularly when the treatment includes services classified as major care. Delta Dental will provide a pretreatment estimate of the amount that will be covered under the Plan and may suggest an alternate treatment plan if a part of your dentist's initial treatment plan is ineligible for coverage. Proposed treatment plans should be mailed to:

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

Note that Delta Dental's pretreatment estimate is not a guarantee of payment. You still must file a claim under the procedures set out in the Claims and appeals chapter.

### SAVE MONEY BY USING NETWORK DENTISTS

As a dental plan participant, you can use any dentist and receive benefits for covered expenses under the Plan. However, you will save money and time when you use Delta Dental dentists. Providers contracted with Delta Dental's Premier and PPO networks have agreed to accept the dental plan's maximum plan allowance as payment in full for a covered procedure, so you will pay no more than the coinsurance percentage specified under the dental plan (after any applicable annual deductible has been met). In addition, Delta Dental's network providers also provide Delta Dental participants with discounted prices. When you see a Delta Dental PPO provider, you may be able to save more because PPO providers have agreed to accept reduced fees for covered procedures when treating Delta Dental participants. You may save time because network dentists will often file your claims for you.

The Delta Dental PPO network is an extensive nationwide network of dentists, but is not as widely available as the Delta Dental Premier network. Refer to the chart entitled Coverage under the dental plan earlier in this chapter for details on how coverage terms for preventive and diagnostic care may differ based on the availability of PPO dentists in your area. To find a Delta Dental PPO or Delta Dental Premier dentist near you, see Dental plan resources at the beginning of this chapter.

IT PAYS TO USE NETWORK DENTISTS

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

## Filing a dental claim

If you use a Delta Dental network dentist, your dentist will often file the claim for you. If you use a non-network dentist, you may need to file a claim. The dentist may be paid directly from the dental plan if the dentist is a Delta Dental network dentist. If you use a non-network dentist, the payment will be made to you.

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You or your dental provider must file a claim within 18 months from date of service or your claim will be denied. Please mail your claim to:

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

Failure to mail your claim to the correct address may result in the denial of your claim.

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

### FILING A DENTAL PRESCRIPTION CLAIM

If you do not have medical coverage with the Plan, you will need to file a claim for any dental prescription by completing a claim form with Delta Dental, and your dental prescription will be subject to the terms and limits described earlier in this section. A copy of the claim form can be found on the WIRE and WalmartOne.com. If you have medical coverage with the Plan, your dental prescriptions would be covered as any medical prescription.

### IF YOU OR A FAMILY MEMBER HAS COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you have coverage under more than one dental plan — for example, you have coverage under the Plan and your spouse's/partner's employer-sponsored dental plan, the coordination of benefits provisions will apply. The dental plan has the right to coordinate with "other plans" under which you are covered so the total dental benefits payable will not exceed the level of benefits otherwise payable under the dental plan. "Other plans" are fully described in If you have coverage under more than one medical plan in The medical plan chapter. Dental benefits will not exceed annual or lifetime maximums.

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## What is covered under the dental plan

The dental plan covers the services listed in this section. There are some limitations. If you have any questions about what is and what is not covered under the dental plan, please call Delta Dental at 800-462-5410.

### PREVENTIVE AND DIAGNOSTIC CARE

Preventive and diagnostic care are covered without having to meet the annual deductible.

**Bitewing or periapical X-rays:** Periapical X-rays as needed and four bitewings in a calendar year.

**Cleaning (dental prophylaxis):** One prophylaxis, including cleaning, scaling and polishing of the teeth, is covered twice during a calendar year. Two additional cleanings are allowed during a pregnancy and up to three months following delivery.

**Fluoride treatment:** Covered once in any consecutive 12-month period for participants under age 19.

**Full-mouth debridement:** Limited to once per lifetime.

**Full-mouth survey or panoramic X-rays:** Limited to one procedure in any consecutive 60-month period. A full-mouth series is any combination of 14 or more periapical and/or bitewing X-rays taken on the same date.

**Oral evaluations:** Benefits are payable as follows:

- Routine oral evaluation: Two evaluations covered during a calendar year.
- Comprehensive detailed oral evaluation or periodontal evaluation: Initial comprehensive oral evaluation will be payable subject to the routine oral evaluation time limitations. Subsequent oral evaluations submitted by the same provider within three years will be processed as routine oral evaluations.

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

**Preventive resin restoration:** Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth every five years.

**Sealant repair:** Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Not covered during the first 24 months of the initial placement of the sealant. Limited to one treatment per tooth every 24 months. A sealant or a sealant repair is not covered when the tooth has previously received a preventive resin restoration.

**Sealants:** Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth per lifetime.

**Space maintainers:** Covered for participants under age 19.

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### BASIC CARE

After you meet the annual deductible, the Plan pays 80% of the maximum plan allowance for basic care.

**Amalgam and composite resin fillings:** Benefits are payable once per tooth surface in any consecutive 24-month period. Benefits for composite resin fillings for posterior teeth will be 70% of the maximum plan allowance up to the maximum benefit.

**Endodontics:** Includes pulp therapy and root canal therapy. See Root canal therapy in Limited benefits later in this chapter.

**Extractions:** Nonsurgical extractions.

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



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**Occlusal guard:** Benefits are payable once every five years. Repair and/or reline of occlusal guard provided once in any consecutive 24-month period.

**Occlusal orthotic device (TMJ appliance):** Benefits are payable once every five years.

**Periodontal maintenance:** Periodontal maintenance is covered only if done 30 days or more after the completion of active periodontal treatment. Thereafter, periodontal maintenance is allowed once every 180 days.

**Prescription drugs and medicines:** Written for dental purposes and dispensed by a licensed pharmacist.

## MAJOR CARE

After you meet the annual deductible, the Plan pays 50% of the maximum plan allowance for major care.

**Anesthesia/general anesthetics and IV sedation:** Provided only in the following circumstances:

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

**Complete and partial removable dentures:** The Plan will cover a denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge. When alternate treatment plans are available, the Plan will cover the professionally accepted, standard course of treatment. For example, a bridge will be allowed only when a partial denture will not suffice. Complete and partial or removable dentures are not payable for patients under the age of 16. A denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge, will be covered only if the existing denture, partial denture or fixed bridge is at least five years old and cannot be repaired. See also Prosthetics in Limited benefits later in this chapter.

**Implants:** Surgical placement of an implant body is covered once in every seven-consecutive-year period.

- The abutment to support a crown is covered once in every seven-consecutive-year period.
- An implant or abutment-supported retainer is covered once in every seven-consecutive-year period.
- An implant maintenance procedure is covered once in any 12-consecutive-month period.
- Implant removal is covered once in a lifetime per tooth. Implants are not payable for patients under the age of 16.

**Crowns, cast restorations, inlays, onlays and veneers:** Covered only when the tooth cannot be restored by amalgam or composite resin filling.

- Replacement will not be covered unless the existing crown, cast restoration, inlay, onlay or veneer is more than seven years old and cannot be repaired.

  **NOTE:** Accidents as a result of biting or chewing are not an exception to the seven-year wait for crown replacements.
- For participants under age 14, benefits for crowns on vital teeth are limited to resin or stainless steel crowns, unless there is a history of root canal therapy or recession of the pulp.
- Treatment is determined according to the alternate treatment plan limitation. See Alternative treatment plans in Limited benefits later in this chapter.

**Occlusal adjustment (limited):** Covered only if done 180 days or more after completion of initial restorative, prosthodontic and implant procedures that include the occlusal surface.

**Oral surgery:** Surgical extractions and extractions of wisdom teeth, including preoperative and postoperative care, except for those services covered under the Associates' Medical Plan. Oral sedation and/or nitrous oxide (analgesia) are not covered.

**Outpatient or inpatient hospital costs and additional fees charged by the dentist for hospital treatment:** See Hospital charges in What is not covered under the dental plan later in this chapter.

**Partial fixed bridgework:** See Alternative treatment plans and Prosthetics in Limited benefits later in this chapter.

**Surgical periodontics:** Treatment of the gums — osseous surgery/soft tissue graft, provided in the same area once in any consecutive 36-month period.

## ORTHODONTIA ASSISTANCE

After you have been a participant in the dental plan for 12 months, you are eligible for orthodontia assistance for yourself (the associate). Each of your covered dependents must also participate in the dental plan for 12 months before becoming eligible for orthodontia assistance. (The 12-month wait is waived for localized associates and their covered dependents.)

If the dentist submits a statement at the beginning of a period of orthodontic treatment showing a single charge for the entire treatment, benefits will be paid in the following manner:

- The dentist will receive an initial payment of up to $150
- A prorated portion of the remainder will be paid every three months based on the estimated period for treatment and on continued eligibility, and
- The amount and number of payments are subject to change if the charge or treatment period changes.

Active orthodontic treatment is deemed started on the date the active appliances are first placed. Active orthodontic treatment is deemed completed on the earlier of:

- The date on which treatment is voluntarily discontinued, or
- The date on which the active bands or appliance(s) are removed.

There are certain orthodontia assistance benefits that are not covered. See **What is not covered under the dental plan** later in this chapter.

## Limited benefits

**Alternative treatment plans:** When alternative treatment plans are available, the Plan will cover the professionally accepted, standard course of treatment.

**Prosthetics:** The Plan covers the replacement or addition of teeth to dentures, partials or fixed bridgework when needed, while covered under the Plan.

- The replacement of a complete or partial denture will be covered only if the existing denture or partial is at least five years old and cannot be repaired.
- The replacement of a fixed bridge will be covered only if the existing bridge is at least five years old and cannot be repaired.

**Root canal therapy:** Includes bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth.

- Therapeutic pulpotomy is payable for deciduous teeth only.
- Retreatment of a previous root canal is allowed once in a consecutive 24-month period.

**Surgical/nonsurgical periodontics:** Provided once in any consecutive 36-month period.

**Transfer of treatment:** If you transfer from the care of one dentist to another during the course of treatment, or if more than one dentist renders services for one dental procedure, the Plan will pay no more than the amount it would have paid if only one dentist had rendered services.

## What is not covered under the dental plan

**Accidental injury to sound, natural teeth:** Expenses for treatment of accidental injury to sound, natural teeth may be covered under the medical plan. This exclusion does not apply to accidental injuries as a result of biting or chewing; these charges may be covered under the dental plan.

**Beyond the scope of licensure or unlicensed:** Services rendered by a dentist beyond the scope of his or her license, or any services provided by an unlicensed dentist.

**Bridgework:** Repair or recementing of bridgework during the first six-month post-delivery period, and such services received more often than once every five years.

**Cosmetic purposes:** Services performed for cosmetic purposes or to correct congenital, hereditary or developmental malformations. This exclusion does not apply to orthodontic services for the correction of malposed teeth.

**Dentures:** Repair or relining of dentures during the first six-month post-delivery period, and such services received more often than once every five years.

**Elective non-emergency dental services outside the U.S.**

**Experimental or investigational:** Charges for treatment or services, including hospital care, that are experimental, investigational or inappropriate, under protocols established by Delta Dental.

**Governmental agency:** Services provided or paid for by any governmental agency or under any governmental program or law, except charges for legally entitled benefits under applicable federal laws.

**Hospital charges:** Services performed in a hospital or outpatient hospital setting, including but not limited to provider and facility charges.

**Oral sedation:** Oral sedation and/or nitrous oxide (analgesia).

**Orthodontia:** If bands were removed prior to eligibility, unless five years have elapsed before the placement of new bands. Repair or replacement of an orthodontic appliance is not a benefit.

**Orthodontia care:** Services in connection with treatment for the correction of malposed teeth during the first 12 consecutive months that a participant is covered under the dental plan.

**Periodontal splinting:** Charges for complete occlusal adjustments or stabilizing the teeth through the use of periodontal splinting.

**Permanent restorations:** Charges for bases, liners and anesthetics used in conjunction with permanent restorations (fillings).

**Retainers:** Separate charges for retainers (appliances that are intended to retain orthodontic relationship) or habit appliances to address harmful behaviors such as thumb-sucking or tongue-thrusting.

**Services undertaken prior to effective date or during the waiting period for major care or orthodontia services:** Charges for courses of treatment, including prosthetics and orthodontics, which are begun prior to the effective date of coverage or before you are eligible to receive benefits for major care or orthodontia services.



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**Surgical corrections:** Charges for services related to the surgical correction of:

- Temporomandibular joint dysfunction (TMJ)
- Orofacial deformities, and
- Specified oral surgery procedures covered by the Associates' Medical Plan.

**Tooth structure:** Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.

### OTHER CHARGES NOT COVERED

- Any procedure performed for a temporary purpose
- Charges in excess of the maximum plan allowance
- Extraoral grafts
- Hypnosis or acupuncture
- Oral hygiene instruction and dietary instruction
- Plaque control programs
- Repair or replacement of an orthodontic appliance
- Services covered by the Associates' Medical Plan
- Services for which there is no charge
- Teledentistry
- Any other services not specifically listed as covered
- Charges covered by workers' compensation or employers' liability laws
- Services provided by a member of the participant's family, or
- Charges incurred as a result of war.

## If you go on a leave of absence

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

### BREAK IN COVERAGE

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

Your coverage and your eligible dependents' coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. All benefits cease on the date coverage ends, except for completion of operative procedures in progress at the time coverage ends. Operative procedures are defined as, and limited to, individual crowns, dentures, bridges and implants (and the associated implant superstructure), and are considered "in progress" only if all procedures for commencement of lab work have been completed and all operative procedures are completed within 45 days of termination.

See the Eligibility and enrollment chapter for a complete list of events that may cause coverage to end. See the COBRA chapter for information regarding COBRA continuation coverage.

## If you leave the company and are rehired

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). If your break is 30 days or less, the annual deductible and waiting period for orthodontia assistance will not reset. If your break is greater than 30 days, your waiting period for orthodontia assistance will reset. If your break is greater than 30 days but less than 13 weeks, and you have already maintained coverage under the Plan for a minimum of two years, you will have 60 days after resuming work 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 may enroll for coverage under the time periods and conditions described in the Eligibility and enrollment chapter.

## If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar plans offered under the Plan). In this case, the annual deductible and waiting period for orthodontia assistance will not reset.

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

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# The vision plan

## WHERE CAN I FIND?


| | |
|---|---|
| Your vision plan | 110 |
| How the vision plan works | 110 |
| How to use the plan | 111 |
| What is not covered | 111 |
| Breakage and loss of eyewear | 111 |
| Filing a vision claim | 111 |
| If you go on a leave of absence | 112 |
| When vision coverage ends | 112 |
| If you leave the company and are rehired | 112 |
| If you drop coverage and re-enroll | 112 |


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# The vision plan

**The vision plan is designed to address your needs for proper eye care by helping you pay for routine eye exams, lenses, frames and contact lenses. You can receive the same benefits whether you see a provider from a Walmart Vision Center, Sam's Club Optical or the VSP network.**

VISION PLAN RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Locate a Walmart Vision Center or Sam's Club Optical provider | Go to the WIRE or WalmartOne.com | |
| For detailed information about vision plan coverage or to locate a VSP network provider | Go to vsp.com and enter your member number | Call VSP at 866-240-8390 |
| Get the cost for vision plan coverage | Go to the WIRE or WalmartOne.com | Call People Services at 800-421-1362 |

## What you need to know about the vision plan

- All hourly and management associates and their eligible dependents (except for the spouses/partners of part-time associates, temporary associates and part-time truck drivers) can enroll in the vision plan when they are eligible.
- Coverage under the vision plan is separate from coverage under the medical plan, which generally does not cover charges for routine eye care. Eligible associates interested in vision coverage for services not covered by the medical plan must enroll separately in the vision plan.
- In order for benefits to be paid, you must use a Walmart Vision Center or Sam's Club Optical provider or a provider in VSP's network. No benefits are available if you see a non-network provider.
- You may see any Walmart Vision Center, Sam's Club Optical or VSP network provider for care.
- You may purchase contact lenses online at WalmartContacts.com or SamsClubContacts.com. VSP will coordinate the amount of your purchase eligible for benefit coverage. Go to vsp.com or call VSP at 866-240-8390 for details about your contact lens benefit.
- Associates who have access to an HMO plan that offers vision coverage will need to compare the HMO plan's coverage and the benefits offered by the vision plan and decide which option best meets their needs.
- If you have medical plan coverage with the Associates' Health and Welfare Plan, the VSP telephone number will appear on your plan ID card, which will be mailed to your home address. If you are enrolled in an HMO or if you enroll for vision coverage only or dental and vision coverage only, you will receive a VSP ID card, which will be mailed to your home address.

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## Your vision plan

Walmart offers the vision plan to help eligible associates pay for eligible routine eye care. The vision plan is administered through VSP. You may access care under the vision plan through a Walmart Vision Center or Sam's Club Optical facility, or through a provider in VSP's nationwide network.

## How the vision plan works

The vision plan covers a routine eye exam once every calendar year, lenses once every calendar year, frames once every calendar year or contact lenses once every calendar year. The vision plan will pay benefits for prescription contact lenses or prescription eyeglasses. If you choose contact lenses, you will not be eligible for lenses or frames again until the next calendar year. Benefits are paid as shown in the chart below. Walmart providers and VSP network providers have agreed to provide their services to covered associates and their covered dependents for a prearranged fee; all you pay is the applicable copay and the cost of any non-covered or elective items. VSP pays the rest directly to the provider. No benefits are available if you see non-network providers.

**Additional charges.** Charges for any of the following items will be the associate's responsibility. Call VSP for more information.

- Blended lenses
- Oversize lenses
- Photochromic or tinted lenses other than Pink 1 or 2 allowance
- Coated or laminated lenses
- No-line multifocal lenses
- High-index lenses
- Anti-reflective coating
- Color coating
- Mirror coating
- Optional cosmetic processes
- Cosmetic lenses, and
- Frames or contacts that cost more than your allowance.

VISION PLAN BENEFITS

| | Walmart Vision Center | Sam's Club Optical | VSP network providers |
|---|---|---|---|
| **Routine exam copay**<br>Once every calendar year | $4<br>*Limitations apply for low-vision testing or supplemental testing for individuals whose vision problems are not correctable with regular lenses.* | | |
| **Materials copay** | $4<br>*Applies with purchase of frames, lenses or both. Copay is charged only once when frames and lenses are purchased together.* | | |
| **Progressive lens copay** | $55 | | |
| **Lenses**<br>Once every calendar year<br>• Single vision<br>• Lined bifocal<br>• Lined trifocal<br>• Progressive multifocal | 100% covered<br>*Standard lenses are covered after applicable copay. Check with your optical team for lenses offered under benefit.* | | |
| **Frames**<br>Once every calendar year | $130 allowance<br>*Charges above the frame allowance are the responsibility of the associate.* | | |
| **Contact lenses**<br>Once every calendar year<br>In lieu of glasses | $130 contact lens allowance<br>*Fitting and evaluation fee up to $60 may apply. Any charges above the contact lens allowance are the responsibility of the associate.* | | |

**NOTE:** State and/or local sales taxes may apply and will reduce the vision benefit. No benefits are available if you see non-network providers.

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## How to use the plan

Follow these steps to use a Walmart Vision Center or Sam's Club Optical provider or a VSP network provider for your vision care.

| | |
|---|---|
| **STEP 1** | To find a Walmart Vision Center or Sam's Club Optical provider, go to the WIRE or WalmartOne.com; to find a provider in the VSP network, call 866-240-8390 or go to vsp.com and enter your member number. |
| **STEP 2** | When you call the provider to make an appointment, identify yourself as a VSP member and give the office your first name, last name and date of birth, plus the patient's name (if different). The provider's office will contact VSP to verify your eligibility. |
| **STEP 3** | At your visit, pay your copay and/or any other required amount directly to the Walmart Vision Center or Sam's Club Optical or VSP network provider. The provider's office will make its own arrangements for reimbursement and handle any other administrative tasks required. |

## What is not covered

Regardless of whether you use a Walmart Vision Center, Sam's Club Optical or VSP network provider, there are some expenses the vision plan will not pay for, including:

- Charges for eye exams, lenses or frames that:
  - you are not legally obligated to pay for or for which no charge would be made in the absence of vision coverage
  - exceed plan maximums
  - are not necessary according to accepted standards of ophthalmic practice, or not ordered or prescribed by the attending physician or optometrist
  - do not meet accepted standards of ophthalmic practice, including charges for experimental or investigational services or supplies
  - are received as a result of eye disease, defect or injury due to an act of declared or undeclared war
  - are for any condition, disease, ailment or injury arising out of and in the course of employment compensable under a workers' compensation or employers' liability law and were ordered before the patient became eligible for coverage or after coverage ends
  - are received free from any governmental agency by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body, and
  - are payable under any health care program supported in whole or in part by federal funds or any state or political subdivision.
- Medical or surgical treatment or supplies covered under your medical plan or, if available, HMO
- Professional services or eyewear connected with orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography, and other services/materials not covered by the Plan
- Replacement of broken lenses or frames after one year from purchase
- Replacement of lost lenses or frames unless the patient is otherwise eligible under the frequency provisions, as detailed in the Vision plan benefits chart
- Service contract fees
- Plano lenses (nonprescription lenses less than .50 diopter)
- Services from any non-network providers — i.e., any provider that is not affiliated with a Walmart Vision Center or Sam's Club Optical, or that is not a VSP network provider.

## Breakage and loss of eyewear

If you're covered under the Plan and you break or damage your eyewear within the first year of purchase, you can return to your Walmart Vision Center, Sam's Club Optical or VSP network provider for replacement or repair. Some warranties on eyewear may be longer than one year; check with your eyewear provider for specific warranties.

Lost eyewear is not covered under the Plan and is the responsibility of the associate.

## Filing a vision claim

When you use the vision plan, claims for services generally do not need to be filed; see How to use the plan above for a description of payment arrangements. When filing a claim is necessary — for example, if you are newly enrolled in the vision plan when you see a vision provider and your personal information is not yet on file with VSP — you must return to the vision provider after your information is in the system and ask the provider to file the claim on your behalf. Your claim will be processed according to the terms described in the Claims and appeals chapter.

### IF YOU OR A FAMILY MEMBER HAS COVERAGE UNDER MORE THAN ONE VISION PLAN

If you have coverage under more than one vision plan — for example, you have coverage under the Plan and your spouse/partner's employer-sponsored vision plan, the coordination of benefits provisions may apply. The vision plan has the right to coordinate with "other plans" under which you are covered, so the total vision benefits payable will not exceed the level of benefits otherwise payable under the vision plan. Under the vision plan, "other plans"

refers only to other plans administered by VSP. There is no coordination-of-benefits provision with vision coverage providers other than VSP. "Other plans" are fully described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

## If you go on a leave of absence

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

### BREAK IN COVERAGE

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

If you have received covered vision services prior to your leave, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames every calendar year) will continue to apply after your return.

## When vision coverage ends

Your coverage and your eligible dependents' coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan.

See the **Eligibility and enrollment** chapter for a complete list of events that may cause coverage to end. See the **COBRA** chapter for information regarding COBRA continuation coverage.

## If you leave the company and are rehired

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). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work 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 may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

## If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar coverage offered under the Plan).

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

If you have received covered vision services prior to your absence, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames once every calendar year) will continue to apply after your return.

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# COBRA

## WHERE CAN I FIND?


| | |
|---|---|
| COBRA — Medical, dental and vision continuation after coverage ends | 116 |
| COBRA qualifying events | 116 |
| Paying for COBRA coverage | 118 |
| How long COBRA coverage lasts | 119 |
| When COBRA coverage ends | 121 |


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# COBRA

**It's important to maintain the financial protection your health care coverage provides for you and your family. If you leave Walmart or a covered family member is no longer eligible for coverage under the Plan, you or any covered family member may be able to continue medical, dental and vision coverage through the continuation provisions of the Plan and as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA). (Additional health coverage options may be available to you through the Health Insurance Marketplace, including less-expensive options, or you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, such as a spouse's plan.) The Plan contracts with WageWorks, a Third Party Administrator, to administer COBRA. Please familiarize yourself with this one-time opportunity for coverage continuation by carefully reading the COBRA notification and noting enrollment deadlines.**

COBRA RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Contact People Services within 60 calendar days of a divorce, legal separation, termination of a relationship with a partner (as defined below) or ineligibility of dependent(s) | | Call People Services at 800-421-1362 or provide notification in writing to: Walmart People Services 508 SW 8th Street, Bentonville Arkansas 72716-3500 |
| Contact WageWorks, the Third Party Administrator for COBRA, for questions regarding eligibility, enrollment, premiums and notification of a second qualifying event | Go to mybenefits.wageworks.com | Call 800-570-1863 |

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## What you need to know about your COBRA rights

- If medical, dental or vision coverage ends for you and/or your eligible dependent(s) under the Plan because of a COBRA qualifying event (as defined under COBRA qualifying events below), you and/or your eligible dependent(s) may be able to continue medical, dental or vision coverage.
- The Plan extends continuation coverage to you and all eligible dependents. Your eligible dependents are your spouse; your dependent children to age 26 (or older, if incapable of self-support); someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support; and your partner (as defined under COBRA qualifying events below). References to COBRA in this section are to the Plan's continuation coverage, which may be more favorable to participants and dependents than the continuation coverage legally required under COBRA.
- You and/or your eligible dependent(s) must contact People Services by calling 800-421-1362 within 60 calendar days of the following COBRA qualifying events to request COBRA continuation coverage or COBRA eligibility will be lost: divorce, legal separation, termination of the relationship with your partner (as defined under COBRA qualifying events below) or ineligibility of dependents (for instance, a dependent no longer satisfies the requirements for coverage, such as attainment of age 26).
- If your employment ends or you lose medical, dental or vision coverage due to a reduction in hours that makes you ineligible for coverage, you will automatically receive a COBRA election notice offering you the opportunity to enroll in COBRA coverage. If you die, your spouse, partner or dependent children will receive such notice if they had coverage under the Plan immediately before your death.
- The COBRA election period lasts until 60 days after the date that your Plan coverage terminates or 60 days after the date of your COBRA election notice, if later. To enroll, you must:
  1. Complete and mail your COBRA election notice or go online at mybenefits.wageworks.com, and
  2. Make your premium payment by mail, online at mybenefits.wageworks.com or call 800-570-1863 no later than 45 days from the date on which you make your election.

  If you have any questions or need assistance with enrollment, please call 800-570-1863.

## COBRA — Medical, dental and vision continuation after coverage ends

If medical, dental or vision coverage under the Plan ends for you or your eligible dependent(s), you and/or your eligible dependent(s) may be able to continue your coverage under the Plan's continuation coverage provisions, which comply with the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

This coverage is called "COBRA coverage." An event that makes you and/or your eligible dependent(s) eligible for COBRA coverage is called a "qualifying event."

You must have had medical, dental or vision coverage under the Plan on the day prior to your qualifying event date to be eligible for COBRA coverage, unless coverage ended during a leave of absence, as described below. You are only able to continue medical, dental or vision coverage if you had such coverage the day prior to your qualifying event. You may choose a lesser tier level and/or select an alternate medical plan, if applicable.

If after you elect COBRA coverage, you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options.

If you have HMO coverage at the time of your qualifying event and the state in which you reside has more favorable coverage continuation rules than federal COBRA, the HMO will generally follow those state rules. For more information on state continuation rights, contact your HMO provider.

COBRA applies only to medical, dental and vision coverage and does not apply to critical illness insurance, accident insurance, company-paid life insurance, optional associate life insurance, optional dependent life insurance, short-term disability, long-term disability or accidental death and dismemberment (AD&D) benefits. See the **Critical illness insurance**, **Accident insurance**, **Company-paid life insurance**, **Optional associate life insurance**, **Optional dependent life insurance** and **Accidental death and dismemberment (AD&D) insurance** chapters in this book for more information regarding portability and/or conversion rights. The Plan also provides continuation coverage for Resources for Living. See the **Resources for Living** chapter for more information.

### IF YOU ARE ON LEAVE OF ABSENCE

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

**NOTE:** If you and any eligible dependent(s) were enrolled in medical, dental or vision coverage under the Plan on the day before your leave of absence began but you dropped coverage during your leave of absence or your coverage was canceled due to nonpayment of premiums during the leave, you will still be offered COBRA when your employment terminates. If you elect COBRA coverage, it will run from the date following your employment termination date. This means that if you or any eligible dependent elects COBRA at the end of a leave of absence during which coverage was dropped or canceled for nonpayment, the elected COBRA coverage will not be effective retroactive to the date coverage was dropped or canceled, but will be effective on the date following your employment termination date.

## COBRA qualifying events

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

- Your employment with Walmart ends for any reason, or
- You are no longer eligible for medical coverage because the number of hours you regularly work for Walmart has decreased, making you ineligible for coverage under the Plan.

Your spouse or partner (as such term is defined on the following page) is eligible for COBRA if coverage for the spouse or partner ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your spouse or partner is no longer eligible for medical, dental or vision coverage because the number of hours you regularly work for Walmart has decreased, making them ineligible for coverage under the Plan, or
- You and your spouse divorce or legally separate.

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- You and your partner no longer meet the definition of having a "partnership" for purposes of the Plan. A partner is defined as any of the following:
  - Your domestic partner, as long as you and your domestic partner:
    - 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 to each other in a manner that would bar 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 with whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage by the state or country in which the relationship was created.
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must contact People Services by calling 800-421-1362 within 60 days of enrolling in Medicare Part D), or
- You die.

Your eligible dependent(s) other than a spouse or partner (as such term is defined above) is eligible for COBRA if coverage for the dependent(s) ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your eligible dependent(s) is no longer eligible for medical, dental or vision coverage because the number of hours you regularly worked for Walmart has decreased, making them ineligible for coverage under the Plan
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate. (You or your eligible dependent must contact People Services by calling 800-421-1362 within 60 days of enrolling in Medicare Part D)
- Your dependent child(ren) no longer meets eligibility requirements (e.g., the end of the month in which a dependent turns age 26), or
- You die.

**NOTIFICATION**

In general, Walmart will notify WageWorks, the Plan's Third Party Administrator for COBRA (hereinafter referred to as "COBRA administrator") if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment or a reduction in hours of employment that makes you ineligible for coverage under the Plan. Walmart will generally make this notification to the COBRA administrator within 30 days after the qualifying event.

Federal law places responsibility upon you or your eligible dependent(s) to notify People Services within 60 calendar days after the later of the date of a divorce, legal separation, termination of your partnership (as defined earlier in this section) or ineligibility of dependent(s), or the date on which you will lose coverage under the Plan as a result of one of these events. If you or your eligible dependent(s) does not notify People Services within 60 days, your dependent(s) will not be eligible for COBRA. You or your eligible dependent(s) must also notify the COBRA administrator of a second qualifying event or Social Security disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the Plan. If notice is not provided of a second qualifying event or extension request within 60 days from the later of the date of the second qualifying event or the date on which you lost (or will lose) coverage as a result of a second qualifying event, COBRA continuation rights will expire on the date that your or your eligible dependent's initial COBRA coverage period expires.

Under the law, you or your eligible dependent is responsible for notifying People Services of your divorce, legal separation, termination of your relationship with a partner (as such term is defined earlier in this section) or a child's loss of dependent status. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later). You or your eligible dependent can provide notice on behalf of yourself as well as any eligible dependent affected by the qualifying event. Provide notice of the qualifying event to People Services by calling 800-421-1362 or writing to:

Walmart People Services
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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The notice must include the following information:

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

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

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you and your eligible dependent(s) at your last known address. The election notice will describe your right to continue medical, dental or vision coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect such coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. You can contact the COBRA administrator by logging on to mybenefits.wageworks.com or by calling 800-570-1863. If you do not elect COBRA continuation coverage within the 60-day period, you will lose your right to elect COBRA coverage.

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**NOTE:** You may be asked to provide documentation of the qualifying event in order to receive COBRA coverage. Notify the COBRA administrator of any change of address if you elect COBRA coverage.

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

COBRA is provided subject to the eligibility requirements for continuation coverage for you and your eligible dependents under the law and the terms of the Plan. To the extent permitted by law, the Plan Administrator will retroactively terminate your COBRA coverage if you are later determined to be ineligible.

### COBRA STATUS CHANGE EVENTS

After the COBRA election period, you or your eligible dependent may not change or add to the elected COBRA coverage without a status change event outside annual enrollment or a subsequent qualifying event. For information about status change events, see Changing your benefits during the year: status change events in the Eligibility and enrollment chapter. If a status change event occurs (such as if a child is born), you must notify the COBRA administrator within 60 calendar days of the event. Supporting documentation may be required. As long as you are on COBRA, you will have the right to make changes to your coverage during any annual enrollment period.

Unless otherwise provided in the Plan, if you add a spouse or partner (as such term is defined above) or other eligible dependent due to a status change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to any applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options. If you change from one of the HRA plans to another during the Plan year as the result of a status change event, the amount credited to your HRA will be prorated according to the time remaining in the year. If you change from one of the HRA plans to a non-HRA plan, your HRA balance will be forfeited. See The medical plan chapter for more information.

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If you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductibles and out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent, unless you change plan options as described above. You will also receive credit toward any waiting periods.

In the event of a status change, you or your eligible dependent may change benefit coverage to another benefit tier under the Plan only if the change in coverage is consistent with the status change event.

If you move to a new location and this affects your medical coverage (i.e., moving from an HMO area to a non-HMO area), you will have 60 calendar days from the date you notify the COBRA administrator of the address change to select a different plan. If you do not submit your selections within 60 days, you will automatically be enrolled in a predetermined plan.

## Paying for COBRA coverage

You and/or your eligible dependent(s) will be responsible for both the associate portion of the premium and the portion that was previously paid by the company, plus a



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2% administrative fee (50% administrative fee in cases of the 11-month disability extension). The letter sent to you and your eligible dependent(s) following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

**Initial COBRA premium:** Your first payment will be due 45 days after you elect COBRA and must cover the cost of COBRA coverage from the qualifying event through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment should equal the premiums for October and November and is due on or before December 30, which is the 45th day after the date of her COBRA election. As described below, ongoing premiums are due the first day of each month, with a 30-day grace period. So Sue's December payment will also be due no later than December 31, the end of the 30-day grace period for the December coverage period.)

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

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

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

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice. Premiums are due regardless of your receipt of a payment invoice. If you are paying by mail, attach your payment to the invoice and mail to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

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

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

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

## How long COBRA coverage lasts

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

DURATION OF COBRA COVERAGE

| Event | Associate | Dependent(s) |
|---|---|---|
| • Your employment with the company ends for any reason<br>• You are no longer eligible for coverage under the Plan due to a reduction in hours | 18 months from the date of the event | 18 months from the date of the event |
| • Your death<br>• Your marital (or partnership) status changes<br>• Dependent(s) no longer meets eligibility requirements (e.g., turns age 26) | Not applicable | 36 months from the date of the event |
| You enroll in Medicare less than 18 months prior to your termination of employment or reduction in hours | 18 months from the date of termination of employment or reduction in hours | Up to 36 months from the date the associate enrolled in Medicare |
| You enroll in Medicare Part D | Not applicable | 36 months from the date the associate enrolled in Medicare Part D |
| Disability extension is obtained | 29 months from the date of the original event | 29 months from the date of the original event |
| Second qualifying event — you must notify the COBRA administrator within 60 days of the second qualifying event or the date of loss of coverage, if later | Not applicable | Up to 36 months from the date of the original event |

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## IF YOU ARE ENTITLED TO MEDICARE

If you are eligible for Medicare Parts A and/or B and terminate employment with the company (or lose coverage under the Plan), you should be aware that if you do not enroll in Medicare Parts A and/or B during the Medicare special enrollment period, you may have to wait to enroll in Medicare Parts A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher Medicare premium when you do enroll. The eight-month special enrollment period runs from the date that you are no longer employed by the company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, please refer to Medicare's *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling 800-633-4227 or from the Medicare website at medicare.gov.

Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment, or a reduction in hours of employment, your eligible dependents can elect COBRA for a period of not more than 36 months from the date you became eligible for Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependent(s) must notify the COBRA administrator at 800-570-1863 of your Medicare status in order to ensure your maximum coverage period is properly calculated.

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## IF YOU OR AN ELIGIBLE DEPENDENT IS DISABLED

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

- The Social Security Administration determines that you or your eligible dependent(s) is disabled
- The disability exists at any time within the first 60 calendar days of COBRA coverage, and
- You and/or your eligible dependent(s) notifies the COBRA administrator of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration disability determination Notice of Award letter to the COBRA administrator within your initial 18-month COBRA period and within 60 days of the later of:
  - The date of your qualifying event
  - The date of your Social Security Administration disability determination Notice of Award, or
  - The date on which you and/or your eligible dependent(s) loses coverage under the Plan as a result of the qualifying event.

In the absence of an official Notice of Award from Social Security, the Plan may accept other correspondence from the Social Security Administration if that correspondence explicitly includes all information the Plan needs in order to grant the extension and is submitted to the COBRA administrator within the time frames listed above.

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

The COBRA premium for the 19th through the 29th month of COBRA coverage generally is the amount you were paying before the qualifying event, plus the amount the company was paying, plus a 50% administrative fee, or 150% of the full premium amount.

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However, if the disability extension applies, but the disabled qualified beneficiary family member is not enrolled in COBRA coverage, the COBRA premium for the covered family members for the extended period is limited to 102%. You or your eligible dependent(s) must notify the COBRA administrator no later than 30 days after the Social Security Administration determines that you or your eligible dependent(s) is no longer disabled.

## IF YOU HAVE A SECOND QUALIFYING EVENT WHILE ON COBRA

While an associate cannot receive an extension of COBRA coverage due to a second qualifying event, your eligible dependent(s) who has COBRA coverage due to your termination of employment, or a reduction in hours of



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employment that makes you ineligible for coverage under the Plan, may receive COBRA coverage for up to a total of 36 months if a second qualifying event occurs during the original 18-month continuation coverage period (or 29-month coverage period, in the event of a disability extension).

The following can be second qualifying events:

- Your death
- Your divorce, legal separation or termination of a relationship with a partner (as such term is defined earlier in this chapter)
- Your child is no longer eligible for medical, dental or vision coverage (e.g., a dependent turns age 26), or
- Your enrollment in Medicare Part D.

If a second qualifying event occurs while your eligible dependent(s) has COBRA coverage, their COBRA coverage may last up to 36 months from the date of the first qualifying event (the date of your termination of employment, or reduction in hours of employment that makes you ineligible for coverage under the Plan).

To receive the extension of the COBRA coverage period, you or your eligible dependent(s) must notify the COBRA administrator of the second qualifying event within 60 calendar days of the date of the event or loss of coverage following the event, if later. If the COBRA administrator is not notified of the second qualifying event during the 60-day period, your eligible dependent(s) cannot get the COBRA coverage extension and the coverage will be terminated as of the date your initial COBRA period expired.

## When COBRA coverage ends

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

- The company no longer provides medical, dental or vision coverage to any of its associates
- Excepting the initial 45-day payment period, if COBRA payment is not made within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you will have until the next business day in order to have your payment postmarked or paid)
- You or your eligible dependent(s) becomes covered by another group health, dental or vision plan after electing COBRA coverage
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), or
- You or your eligible dependent(s) submits a fraudulent claim or fraudulent information to the Plan.

### FILING AN APPEAL

You have the right to appeal an enrollment or eligibility status decision related to your COBRA coverage. See Appealing an enrollment or eligibility status decision in the Claims and appeals chapter for more information.

# Resources for Living®

## WHERE CAN I FIND?


| | |
|---|---|
| Using Resources for Living (RFL) | 124 |
| RFL counseling services | 124 |
| RFL legal and financial services | 124 |
| RFL work-life services | 125 |
| When RFL benefits end | 125 |
| Filing a claim for RFL benefits | 125 |


018977

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# Resources for Living®

**Resources for Living (RFL) is a valuable, confidential counseling and wellbeing information service that's free to all Walmart associates and available from your date of hire. You and your family members can call a professional counselor at any time for help with stress management, family relationships, career issues and other daily challenges. RFL also provides information and resource referrals for assistance with childcare, eldercare, education, finances, wellness and more.**

RFL RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Speak with a counselor or work-life specialist to identify resources and solutions for everyday needs | | Call 800-825-3555 |
| Access articles, tools and resources across a wide range of topics | Go to WalmartOne.com or rfl.com:<br>User ID: Walmart<br>Password: Associate | |
| Access monthly Healthy Living Tips and webinars on a variety of topics | Go to WalmartOne.com or rfl.com:<br>User ID: Walmart<br>Password: Associate | |

## What you need to know about Resources for Living

- RFL is a professional and confidential counseling and information service available 24 hours a day, seven days a week, 365 days a year.
- You and your household members can find counseling, information and work-life assistance.
- All Walmart associates are automatically enrolled in RFL as of their date of hire.
- Walmart or the Plan pays the entire cost of RFL benefits for you and your family.

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## Using Resources for Living (RFL)

Life comes with a lot of demands. Resources for Living (RFL) can help you stress less and live more. You and your household family members can call any time or log into the RFL website to find tools for:

- Stress management
- Budgeting
- Relationships
- Wellness
- Family life and more

RFL can provide telephone, televideo and face-to-face counseling, web-based articles and tools, legal and financial help and a resource team to help you find almost anything — from home repair services to childcare. You and your household members can access services any time by calling RFL at 800-825-3555, 24 hours a day, seven days a week, 365 days a year.

All U.S. associates and their family members are automatically enrolled in RFL as of their first day of employment with Walmart. All benefits under this program are provided and administered by Resources for Living. You can find personalized counseling, support and information for all aspects of your wellbeing, including:

- **Social/Emotional.** Find tips to help you build closer relationships, manage stress and find what motivates you.
- **Career.** Learn new habits that can help you balance your work and life, manage your time and set goals.
- **Financial.** Gain skills to help you set a budget, pay down debt, save for the future and more.
- **Community.** Get connected to local resources such as childcare, eldercare, school, adult education and more.
- **Physical.** Discover how to keep your mind and body healthy with articles on sleep, nutrition, fitness and more.

## RFL counseling services

Whether you need help working through an issue or just someone to talk to, RFL offers you support. You can call and get help with:

- Managing stress
- Building healthy relationships
- Coping with depression, anxiety or substance abuse
- Balancing work and life

You or your household family members can talk to an RFL counselor by telephone, televideo or face-to-face. Just call the RFL toll-free number at 800-825-3555 for support, at no cost to you. If your situation calls for face-to-face behavioral counseling, you can receive up to three sessions at no cost.

## RFL legal and financial services

RFL gives you access to legal and financial experts. Whether you're creating a budget or a will, RFL can help. RFL's specialists can help you:

- Meet your financial goals
- Explore your options related to legal issues
- Make your money go further
- Recover from identify theft, and more

You can receive a half-hour consultation for legal or financial issues or a one-hour consultation for identity theft issues, at no cost to you. Please note that this service does not provide assistance in situations involving employment law.

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## RFL work-life services

You can reach out to RFL for help in balancing the demands of work and home life. Simply call for help with everyday needs such as:

- Care for your child or an older adult
- Military resources
- Pet care
- Adoption resources

RFL's work-life consultant can help you find options for meeting your needs and research details like cost, services and availability.

### CALLING RFL

You and your family can get personalized support all day, every day. Simply call 800-825-3555. Services are available in English and Spanish (other languages available upon request). This service is available at no cost to you. And calls are confidential, except as required by law.

### RFL ON THE WEB

Visit RFL online at rfl.com, for articles, webinars, tools and resources on a variety of topics to help you live well. To log on to rfl.com, simply enter the following:

User ID: Walmart
Password: Associate

You can also access rfl.com by clicking on the single sign-on link found on the RFL page of WalmartOne.com.

## When RFL benefits end

RFL benefits for you and your family end upon your termination of employment for any reason, but your RFL benefit will automatically be continued, at no cost, for you and your family throughout the applicable COBRA period under the Associates' Medical Plan.

## Filing a claim for RFL benefits

You do not have to file a claim for RFL benefits. You may access the RFL website or contact RFL by phone at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services at 800-421-1362 or file a claim by writing to the following address:

People Services
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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

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# Critical illness insurance

## WHERE CAN I FIND?


| | |
|---|---|
| Critical illness insurance | 128 |
| Eligibility and application for critical illness insurance | 128 |
| Critical illness benefits | 128 |
| When your critical illness insurance coverage begins | 129 |
| Filing a claim | 129 |
| Naming a beneficiary | 130 |
| When benefits are not paid | 130 |
| If you go on a leave of absence | 131 |
| When coverage ends | 131 |
| If you leave the company and are rehired | 131 |
| If you drop coverage and re-enroll | 131 |


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



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# Critical illness insurance

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

CRITICAL ILLNESS INSURANCE RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Get detailed information on critical illness insurance | Go to the WIRE, WalmartOne.com or allstateatwork.com/walmart | Call Allstate Benefits at 800-514-9525 |

## What you need to know about critical illness insurance

- All hourly and management associates and their eligible dependents can enroll in critical illness insurance when they are eligible (spouses/partners of part-time hourly associates, temporary associates and part-time truck drivers are not eligible).
- For additional information about critical illness insurance, view the critical illness brochure available online at allstateatwork.com/walmart, the WIRE or WalmartOne.com.
- To view your Certificate of Insurance, visit allstateatwork.com/walmart, the WIRE or WalmartOne.com.
- Not all critical illnesses and diseases are eligible for a payment under this benefit. The list of covered critical illnesses and diseases can be found in this chapter or in your Certificate of Insurance.

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## Critical illness insurance

Critical illness insurance provides a direct benefit if you or any covered dependents are diagnosed with a covered illness or disease. The policy pays benefits for covered critical illnesses and diseases regardless of any other insurance you may have.

Coverage amounts are available in $5,000 increments up to a maximum of $20,000 with no Proof of Good Health required. Coverage must be effective before the date of diagnosis in order for an illness or disease to be covered under the Plan.

Critical illness insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about critical illness insurance, call Allstate Benefits at **800-514-9525** or go to **allstateatwork.com/walmart**.

## Eligibility and application for critical illness insurance

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

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

When applying for critical illness insurance, you may choose:

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

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

- Part-time hourly associate
- Temporary associate, or
- Part-time truck driver.

Benefits-eligible part-time associates may choose:

- Associate only, or
- Associate + child(ren).

For complete information about eligibility and when you can apply for critical illness insurance, see the **Eligibility and enrollment** chapter.

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

## Critical illness benefits

Benefits are payable if you are diagnosed with one of the conditions listed below.

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

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living [ADLs]; see policy for details)
- Coronary artery bypass surgery
- End-stage renal failure
- Heart attack
- Stroke
- Advanced Parkinson's (requires loss of two ADLs)
- Complete loss of sight or hearing (due to illness)
- Quadriplegia (due to illness)
- Complete loss of two eyes, feet, hands, arms or legs (due to illness)
- Coma (lasting seven days) due to illness , or
- Major organ transplant (see note below).

**NOTE:** If you undergo a major organ transplant, as specified in the major organ transplant rider found in the Certificate of Insurance, you will receive 100% of your benefit selection. If you are enrolled in the HSA Plan, you are not eligible for the major organ transplant rider included in critical illness insurance.

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

- Benign brain tumor
- Paraplegia (due to illness), or
- Complete loss of one eye, foot, hand, arm or leg (due to illness)

Other payable benefits include:

- Ambulance: $250 for ground ambulance or $2,000 for air ambulance
- Post-traumatic stress disorder (PTSD): $100 for each day a covered person receives counseling for PTSD; payable once per day per covered person and limited to six days per coverage year
- Carcinoma in situ: 25% of coverage amount
- Complete loss of one or more fingers and/or one or more toes (due to illness): 25% of coverage amount
- Transient ischemic attacks (TIAs): 25% of coverage amount



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- Aneurysm (ruptured or dissecting): 25% of coverage amount
- Specified diseases: 25% of coverage amount
  - Addison's disease
  - Amyotrophic lateral sclerosis (Lou Gehrig's disease)
  - Cerebrospinal meningitis (bacterial)
  - Cerebral palsy
  - Cystic fibrosis
  - Diphtheria
  - Encephalitis
  - Huntington's chorea
  - Legionnaires' disease (confirmation by culture or sputum)
  - Malaria
  - Multiple sclerosis
  - Muscular dystrophy
  - Myasthenia gravis
  - Necrotizing fasciitis
  - Osteomyelitis
  - Poliomyelitis
  - Rabies
  - Sickle cell anemia
  - Systemic lupus
  - Systemic sclerosis (scleroderma)
  - Tetanus, or
  - Tuberculosis.
- Skin cancer benefit: $500
  - Positive diagnosis of skin cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice pathological anatomy, or an osteopathic pathologist. Diagnosis is based on microscopic examination of skin biopsy samples.
  - Skin cancer means basal cell carcinoma and squamous cell carcinoma. For the purposes of this policy, skin cancer does not include malignant melanoma (melanoma is covered under the invasive cancer benefit). It also does not include any conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.
- Recurrence benefit: 50% of original coverage amount for heart attack, stroke, coronary artery bypass surgery, invasive cancer, carcinoma in situ, rabies, aneurysm, benign brain tumor and coma.
- National Cancer Institute (NCI) evaluation and Walmart Centers of Excellence evaluation: $500 for evaluation; $250 for transportation and lodging.
- Lodging benefit: $60 per day for you or each covered family member receiving treatment for a critical illness on an outpatient basis. This benefit is limited to 60 days per calendar year and is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles from your or your covered family member's home.
- Transportation benefit: $0.50 per mile for personal vehicle, up to $1,500, or up to $1,500 round-trip transportation for coach fare on a common carrier. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized free-standing treatment facility. If the treatment is for a covered child and common carrier travel is necessary, the benefit will be paid for up to two adults to accompany the child. This benefit will not be paid if the covered person lives within 100 miles of the treatment facility. For more information, see your Certificate of Insurance or call Allstate Benefits at 800-514-9525.

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

## When your critical illness insurance 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 your status change event or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as indicated above), no critical illness insurance benefit will be paid to your beneficiary(ies).

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

## Filing a claim

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

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, 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 occurred or commenced.

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

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

## Naming a beneficiary

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

You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. You may do this by going to the WIRE, WalmartOne.com or Workday.

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%.

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

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

It's important to keep your beneficiary information current. Proceeds will go to whomever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person, unless state law requires otherwise.

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

### CHANGING YOUR BENEFICIARY

Your beneficiary(ies) can be changed at any time on the WIRE, 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 no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

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

## When benefits are not paid

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

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



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## 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 return to active work as defined by the Plan. 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 critical illness insurance coverage ends on the earliest of the following:

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

Your critical illness insurance coverage for your spouse/partner ends:

- On the last day of the pay period when your job status changes to part-time, temporary or part-time truck driver
- Upon a valid decree of divorce
- Upon termination of domestic partnership
- Upon termination of legal relationship with a person other than a spouse or domestic partner, or
- Upon your death.

### CONTINUATION OF COVERAGE AT TERMINATION

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

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums will be at the same rate that is in effect under critical illness insurance for active associates with the same coverage.

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

### WHEN YOUR DEPENDENT BECOMES INELIGIBLE

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

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

## If you leave the company and are rehired

If you leave the company and then return to work within 13 weeks, you will automatically be re-enrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop 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 may enroll for coverage under the time periods and conditions described in the Eligibility and enrollment chapter.

## If you drop coverage and re-enroll

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

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

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# Accident insurance

## WHERE CAN I FIND?


| | |
|---|---|
| Accident insurance | 134 |
| Eligibility and application for accident insurance | 134 |
| Naming a beneficiary | 134 |
| When your accident insurance coverage begins | 135 |
| Filing a claim | 135 |
| Accident insurance benefits | 135 |
| When benefits are not paid | 136 |
| If you go on a leave of absence | 136 |
| When coverage ends | 136 |
| If you leave the company and are rehired | 137 |
| If you drop coverage and re-enroll | 137 |


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



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# Accident insurance

**An accident can cause unexpected expenses along with injury. If you enroll in accident insurance and are involved in a covered accident while you're off the job, this benefit helps you pay for services necessary as a result of the accident, such as immediate care treatment, hospitalization, physical therapy, transportation and lodging. Benefits are paid directly to you unless you elect to have them paid directly to the provider.**

ACCIDENT INSURANCE RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Get detailed information on accident insurance | Go to the WIRE, WalmartOne.com or allstateatwork.com/walmart | Call Allstate Benefits at 800-514-9525 |

## What you need to know about accident insurance

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

## Accident insurance

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

Accident insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about accident insurance, call Allstate Benefits at 800-514-9525 or go to allstateatwork.com/walmart.

## Eligibility and application for accident insurance

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

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

When applying for accident insurance, you may choose to cover:

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

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

- Part-time hourly associate
- Temporary associate, or
- Part-time truck driver.

Benefits-eligible part-time hourly associates may choose to cover:

- Associate only, or
- Associate + child(ren).

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

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

## Naming a beneficiary

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

You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to the WIRE, WalmartOne.com or Workday.

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%.

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

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

It's important to keep your beneficiary information up to date. Proceeds will go to whoever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person, unless state law requires otherwise.

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

### CHANGING YOUR BENEFICIARY

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



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**IF YOU DO NOT NAME A BENEFICIARY**

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

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

## When your accident insurance coverage begins

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

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

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

## Filing a claim

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

Allstate Benefits
Attn. Walmart Claims Unit
P.O. Box 41488
Jacksonville, 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

Provide the following information for the covered person:

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

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

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

## Accident insurance benefits

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

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

Benefits for services that are eligible for payment as a result of a covered off-the-job accident include:

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

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

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## When benefits are not paid

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

- An injury that occurred as the result of an on-the-job accident
- Injury incurred prior to the covered person's effective date of coverage, subject to the incontestability provision
- Any act of war, whether or not declared, or participation in a riot, insurrection or rebellion
- Suicide, or any attempt at suicide, whether sane or insane
- Any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician
- Dental or plastic surgery for cosmetic purposes, except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury
- Participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports
- Committing or attempting to commit an assault or felony
- Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway, or
- Any injury incurred while a covered person is an active member of the military, naval or air forces of any country or combination of countries. Upon notice and proof of service in such forces, Allstate Benefits will return the prorated portion of the premium paid for any period of such service.

## If you go on a leave of absence

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

### BREAK IN COVERAGE

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. 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 active work 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

Accident insurance coverage for you and/or your dependents will end on the earliest of the following:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of death of you or your dependent
- On the date you or a dependent spouse/partner or dependent 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.

In addition to the terms listed above, accident insurance coverage for your spouse/partner will end (if earlier):

- On the last day of the pay period when your job status changes to part-time, temporary or part-time truck driver
- Upon a valid decree of divorce
- Upon termination of domestic partnership, or
- Upon termination of legal relationship with a person other than a spouse or domestic partner.

### CONTINUATION OF COVERAGE AT TERMINATION

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

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums will be at the same rate that is in effect under accident insurance for active associates with the same coverage.

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



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**WHEN YOUR DEPENDENT BECOMES INELIGIBLE**

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

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

## If you leave the company and are rehired

If you leave the company and then return to work within 13 weeks, you will automatically be re-enrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop 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 may enroll for coverage under the time periods and conditions described in the Eligibility and enrollment chapter.

## If you drop coverage and re-enroll

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

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

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# Company-paid life insurance

## WHERE CAN I FIND?


| | |
|---|---|
| Naming a beneficiary under your company-paid life insurance | 140 |
| When your company-paid life insurance coverage begins | 140 |
| Early payout due to terminal illness | 140 |
| Filing a claim | 141 |
| When benefits are not paid | 141 |
| When coverage ends | 141 |
| EstateGuidance® | 141 |
| Continuing your company-paid life insurance after you leave Walmart | 141 |
| If you leave the company and are rehired | 142 |


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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.



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# Company-paid life insurance

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

COMPANY-PAID LIFE INSURANCE RESOURCES

| Find What You Need | Online | Other Resources |
|---|---|---|
| Change your beneficiary designation | Go to the WIRE, WalmartOne.com or Workday | Beneficiary changes cannot be made over the phone |
| • Get more details about company-paid life insurance<br>• Request an accelerated benefit<br>• Get details about continuing your insurance | | Call Prudential at 877-740-2116 |
| File a claim | | Call Prudential at 877-740-2116 |

## What you need to know about company-paid life insurance

- Wal-Mart Stores, Inc. provides all full-time associates (including full-time hourly pharmacists, field Logistics associates, full-time truck drivers, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time hourly Vision Center managers and Metro professional non-exempt associates) and management associates with company-paid life insurance — there is no cost to you.
- No enrollment is necessary. Coverage will become effective after any applicable waiting period. See the Eligibility and enrollment chapter for details.
- Your coverage amount is equal to your pay, including overtime and bonuses, during the previous 26 pay periods of active status (52 pay periods if paid weekly) prior to your death, rounded to the nearest $1,000, up to a maximum of $50,000. This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- An early payout due to terminal illness is available.
- In addition, if your death occurs outside of a 100-mile radius of your home, there is a benefit for expenses that are incurred to return your body to either a preferred location within the United States, or to your residence at the time of death. The benefit includes expenses for embalming, cremation, a coffin and transportation of your remains. The benefit is the lesser of the cost to return your remains or $10,000.
- This policy has no cash value.

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## Naming a beneficiary under your company-paid life insurance

In order to ensure your company-paid life insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to the WIRE, 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 company-paid 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 beneficiaries unless your beneficiary form states otherwise.

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

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

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 DO NOT NAME A BENEFICIARY

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

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

## When your company-paid life insurance coverage begins

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

## Early payout due to terminal illness

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

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

You are terminally ill if:

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

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

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



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## Filing a claim

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

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

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

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, 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 to a beneficiary in the default list, as specified under If you do not name a beneficiary earlier in this chapter.

## When coverage ends

Your company-paid life insurance coverage ends:

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

This policy has no cash value.

## EstateGuidance®

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

**NOTE:** Your will does not override the beneficiary designation on a life insurance policy or retirement account (such as a 401(k) plan). For this reason, it is important that you review your beneficiary designations, particularly after you have created a will, to make sure your designations are consistent and fully in line with your wishes. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails.

## Continuing your company-paid life insurance after you leave Walmart

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

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

**Portability** enables you to maintain similar term life insurance with Prudential after your employment ends, if certain conditions are met. Proof of Good Health is required to port your coverage. If you do not pass or submit Proof of Good Health, you will be eligible to convert your company-paid life insurance to an individual policy, as described on the next page.

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

1. Your company-paid life coverage ends for any reason other than:
   a. your failure to pay premiums while you were an active associate
   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 are actively at work on the day your company-paid insurance ends.
3. You are less than age 80.
4. Your amount of insurance is at least $20,000 on the day your company-paid insurance ends.

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

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

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

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

## If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for coverage.

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.

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# Optional associate life insurance

## WHERE CAN I FIND?


| | |
|---|---|
| Enrolling in optional associate life insurance | 146 |
| Naming a beneficiary | 146 |
| When your optional associate life insurance coverage begins | 147 |
| Early payout due to terminal illness | 147 |
| Filing a claim | 147 |
| When benefits are not paid | 148 |
| If you go on a leave of absence | 148 |
| When coverage ends | 148 |
| Continuing your optional associate life insurance after you leave Walmart | 148 |
| If you leave the company and are rehired | 149 |
| If you drop or decrease your coverage and re-enroll | 149 |


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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.



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# Optional associate life insurance

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

OPTIONAL ASSOCIATE LIFE 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 life insurance<br>• Request an accelerated benefit<br>• Get details about continuing your insurance | | Call Prudential at 877-740-2116 |
| File a claim | | Call Prudential at 877-740-2116 |

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

- All hourly and management associates can enroll in optional associate life insurance when they are eligible, as described in the Eligibility and enrollment chapter.
- Depending on the coverage amount you choose and when you enroll, you may be required to provide Proof of Good Health.
- You can enroll in, change or drop optional associate life insurance at any time, but if you enroll at any time other than your initial enrollment period, you will have to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- This policy is term life insurance. It has no cash value.

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