Walmart 2024
Benefits

Legal Plan Name:	Geisinger Health Plan
Name used for associate communications:	Geisinger Health Plan
Plan State(s):	Pennsylvania (All other Regions)
Customer Service Number:	(844) 863-6850
Web Address:	www.thehealthplan.com
Active Associate Group #:	10101691-1000-1000
COBRA Group #:	10101691-1000-1001

BENEFIT	2024 PLAN DESIGN
DEDUCTIBLE	$1,000 per individual / $2,000 per family Copayments do not apply to the deductible
ANNUAL OUT-OF-POCKET MAXIMUM	$6,850 per individual/$13,700 per family (deductible, copays and coinsurance accrue toward OOP Max)
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	$35 copay per PCP visit; $75 copay per Specialist visit
PREVENTIVE CARE	Covered 100% (PPACA list of covered services only)
MATERNITY CARE	25% coinsurance after deductible for hospital admission; contact Plan for cost sharing on outpatient maternity office visits
URGENT CARE	$35 copay per visit
TELEMEDICINE	$5 PCP copay, $10 specialist copay
HOSPITAL CARE	
Inpatient	25% coinsurance after deductible
Emergency Room	25% coinsurance per visit (waived if admitted)
Outpatient Surgery	25% coinsurance after deductible
AMBULANCE	25% coinsurance after deductible
DURABLE MEDICAL EQUIPMENT	Covered 100%
DIABETIC SUPPLIES	Covered at various levels depending on type of supply. Contact plan for specifics
INJECTABLES	Covered at various levels based on the drug and the benefit. Contact plan for specifics
SKILLED NURSING FACILITY	25% coinsurance after deductible. Limit 60 days per period of confinement
MENTAL HEALTH	
Inpatient	25% coinsurance after deductible. Including partial hospitalization
Outpatient	$35 copay per visit
SUBSTANCE ABUSE	
Inpatient	25% coinsurance after deductible. Including partial hospitalization
Outpatient	$35 copay per visit
PRESCRIPTIONS	
Retail	$10 generic/greater of $50 or 25% formulary preferred /greater of $75 or 25% formulary non-preferred (or non-formulary w/prior approval due to medical necessity). Brand name non-formulary not covered except for medical necessity with prior approval
Mail-Order	$20 generic/greater of $100 or 25% formulary preferred /greater of $150 or 25% formulary non-preferred (or non-formulary w/prior approval due to medical necessity). Brand name non-formulary not covered except for medical necessity with prior approval
Other Medical Services	
Physical Therapy	$75 copay per visit.
Private Duty Nursing	Not Covered
Prosthetics	Covered 100%
Home Health Care	Covered 100%, when medically necessary and approved by participating skilled Home Health Care professionals
Vision Exams	Covered 100% for annual refractive exam. Limit one exam per year. $75 copay for specialist visit for medical conditions
Hearing Exams	$35 copay per PCP visit; $75 copay per Specialist visit
Chiropractic Services	Discounts apply through Geisinger Health Plan's network of chiropractors
TMJ	25% coinsurance after deductible. 50% coinsurance for splints. Limited to correction or complete degeneration of the TM Joint, consultations to determine the need for surgery, and radiologic determinations of pathology
Organ Transplants	25% coinsurance after deductible. Member is required to obtain prior authorization by the medical director
The following applies to the out-of-pocket maximum	All cost sharing applies to the Out-of-Pocket Maximum
State and Federal Mandates	Walmart's intent is that the plan will be in compliance with all applicable federal and state mandates