Walmart 2025
Benefits

Legal Plan Name:	HMSA
Name used for associate communications:	HMSA
Plan State(s):	Hawaii
Customer Service Number:	(808) 948-6111
Web Address:	www.hmsa.com
Active Associate Group #:	82606-1
COBRA Group #:	69911-2

BENEFIT	2025 PLAN DESIGN
DEDUCTIBLE	None
ANNUAL OUT-OF-POCKET MAXIMUM	Medical: $2,500 per individual / $7,500 per family; Drug: $3,600 per individual / $4,200 per family
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	$14 copay per visit
PREVENTIVE CARE	Covered 100%. Covered recommended preventive services for women. For U.S. Preventive Services Task Force recommended grade A & B screenings and preventive drugs
MATERNITY CARE	20% Coinsurance
URGENT CARE	$14 copay
TELEMEDICINE	No Charge with HMSA's Online Care
HOSPITAL CARE	
Inpatient	20% coinsurance
Emergency Room	20% coinsurance
Outpatient Surgery	20% coinsurance
AMBULANCE	20% coinsurance
DURABLE MEDICAL EQUIPMENT	20% coinsurance; precertification is required
DIABETIC SUPPLIES	Covered 100% for preferred brand name; $50 copay for non-preferred brand name
INJECTABLES	20% coinsurance
SKILLED NURSING FACILITY	20% coinsurance. Limit 120 days per year (Skilled Nursing, Sub Acute and Long term Acute Care Facilities all acculumate collectively to 120 day limit)
MENTAL HEALTH	
Inpatient	20% coinsurance
Outpatient	$14 copay per visit for physician charges; 20% coinsurance for facility charges & testing
SUBSTANCE ABUSE	
Inpatient	20% coinsurance
Outpatient	$14 copay per visit for physician charges; 20% coinsurance for facility charges & testing
PRESCRIPTIONS	
Retail	Tier 1 $7 mostly generic, Tier 2 $50 mostly brand, Tier 3 $75 mostly other brand, Tier 4 $100 mostly preferred specialty, Tier 5 $200 mostly other brand name specialty from a participating provider. Up to a 30 day supply. Non-network Tier 1, Tier 2, Tier 3 retail copay plus 20% of remaining cost. No coverage for non network specialty
Mail-Order	Tier 1 $11 mostly generic, Tier 2 $65 mostly brand, Tier 3 $65 plus $135 mostly other brand. Up to a 90 day supply (specialty drugs not covered). Non-network not covered
Other Medical Services	
Physical Therapy	20% coinsurance; certain services must be precertified
Private Duty Nursing	Not Covered
Prosthetics	20% coinsurance (External prosthetics), precertification is required. 100% covered (Implanted Internal prosthetics), precertification may be required.
Home Health Care	20% coinsurance; Limit 150 days per calendar year
Vision Exams	Not covered
Hearing Exams	$14 but may have multiple copays; Limited to evaluation for use of hearing aids. Contact plan for specifics
Chiropractic Services	Regular plan benefits
TMJ	Not Covered
Organ Transplants	Transplant covered 100% (corneal and kidney covered at 20% coinsurance); Donor services 20% coinsurance. Precertification is required.
The following applies to the out-of-pocket maximum	The following amounts do not apply toward meeting the copayment maximum. You are responsible for these amounts even after you have met the copayment maximum: -Payments for services subject to a maximum once you reach the maximum. -The difference between the actual charge and the eligible charge that you pay when you get services from a nonparticipating provider. -Payments for noncovered services. -Any amounts you owe in addition to your copayment for covered services.
State and Federal Mandates	Walmart's intent is that the plan will be in compliance with all applicable federal and state mandates