

**Walmart 2025
Benefits**

Legal Plan Name: Kaiser Foundation Health Plan
 Name used for associate communications: Kaiser California High Option HMO
 Plan State(s): California
 Customer Service Number: (800) 464-4000 English
 (800) 788-0616 Spanish
 Web Address: www.kp.org
 Active Associate Group #: 600635-0000 (North) 227556-0000 (South)
 COBRA Group #: 600635-7000 (North) 227556-7000 (South)

BENEFIT	2025 PLAN DESIGN
DEDUCTIBLE	\$1,000 individual / \$2,000 family per calendar year. This deductible does not apply to the Services identified with an asterisk (*)
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,550 individual / \$13,100 family per calendar year (includes deductible)
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	\$35 copay per PCP visit; \$60 copay per Specialist visit*; Urgent care is \$35 copay per visit*
PREVENTIVE CARE	Covered at 100%*
MATERNITY CARE	25% coinsurance after deductible for hospital admission Diagnostic visits: \$60 copay per visit.* Contact Plan for cost sharing on all other outpatient maternity office visits
URGENT CARE	\$35 copay per visit
TELEMEDICINE	No charge
HOSPITAL CARE Inpatient Emergency Room Outpatient Surgery	25% coinsurance after deductible 25% coinsurance after deductible 25% coinsurance after deductible
AMBULANCE	25% coinsurance after deductible
DURABLE MEDICAL EQUIPMENT	25% coinsurance per item when deemed medically necessary and prescribed by a Plan physician in accordance with DME formulary guidelines*
DIABETIC SUPPLIES	Insulin: \$10 for 30-day supply for generic at Plan Pharmacy (see prescription benefit)* Diabetic Testing Supplies: 25% coinsurance for up to 100-day supply*
INJECTABLES	Inpatient: Covered at 100% / \$60 Specialist visit Copay Outpatient: \$35 office visit copay applies*
SKILLED NURSING FACILITY	25% coinsurance after deductible. Limit 100 days per benefit period
MENTAL HEALTH Inpatient Outpatient	25% coinsurance after deductible \$35 copay per individual therapy visit; \$17 copay per group visit*
SUBSTANCE ABUSE Inpatient Outpatient	25% coinsurance after deductible \$35 copay per visit individual therapy; \$5 copay group therapy*
PRESCRIPTIONS Retail	Generic: \$10 for up to a 30 day supply, \$20 for a 31–60 day supply, or \$30 for a 61–100 day supply* Brand Name: \$50 for up to a 30 day supply, \$100 for a 31–60 day supply, or \$150 for a 61–100 day supply* Specialty Rx: 25% coinsurance to a maximum of \$250 for up to a 30-day supply*
Mail-Order	Generic: \$20 for up to a 100 day supply* Brand Name: \$100 for up to a 100 day supply* Specialty Rx: 25% coinsurance to a maximum of \$250 for up to a 30-day supply*
Other Medical Services	
Physical Therapy	\$35 copay per visit after deductible
Private Duty Nursing	Not Covered
Prosthetics	Covered at 100% when medically necessary and prescribed by a plan physician*
Home Health Care	Covered at 100%. Limit 100, two-hour visits per calendar year*
Vision Exams	Covered at 100% for preventive screening and refraction. \$60 copay for diagnostic screening by an ophthalmologist*
Hearing Exams	Covered at 100% for preventive screening. \$60 copay per visit for diagnostic screening*
Chiropractic Services	\$15 copay per visit. Limit 30 visits per calendar year (alignment across regions)*
TMJ	25% coinsurance after deductible for surgery. Etiology must be medical not dental
Organ Transplants	25% coinsurance after deductible
The following applies to the out-of-pocket maximum	Cost sharing for Essential Health Services 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