Walmart 2024
Benefits

Legal Plan Name:	Kaiser Foundation Health Plan
Name used for associate communications:	Kaiser California Low 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 #:	600635-0001 (North) 227556-0001 (South)
COBRA Group #:	600635-7101 (North) 227556-7001 (South)

BENEFIT	2024 PLAN DESIGN
DEDUCTIBLE	$1,500 individual / $3,000 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	25% coinsurance after deductible
Emergency Room	25% coinsurance after deductible
Outpatient Surgery	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	25% coinsurance after deductible
Outpatient	$35 copay per individual therapy visit; $17 copay per group visit*
SUBSTANCE ABUSE	
Inpatient	25% coinsurance after deductible
Outpatient	$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