Walmart 2024
Benefits

Legal Plan Name:	Kaiser Foundation Health Plan of Colorado
Name used for associate communications:	Kaiser Colorado Low Option HMO
Plan State(s):	Colorado
Customer Service Number:	(303) 338-3800 Denver Metro Area (800) 632-9700 Other Areas
Web Address:	www.kp.org
Active Associate Group #:	22336 - 105, 106, 113, 117, 122
COBRA Group #:	22336 - 109, 110, 115, 119, 121

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	$6,850 per individual / $13,700 family (includes deductible)
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	$35 copay per PCP visit; $75 copay per Specialist visit. Office administered drugs (excluding prevention immunizations) will be subject to 25% coinsurance, after the deductible is met All copays apply before deductible
PREVENTIVE CARE	Covered 100%
MATERNITY CARE	25% coinsurance after deductible for hospital admission; contact Plan for cost sharing on outpatient maternity office visits. Professional service fee component from pre and post-natal maternity services subject to plan deductible and coinsurance. Preventive component of visits covered 100%.
URGENT CARE	$75 copay per visit. Covered Services received during a visit: 25% Coinsurance.
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
DURABLE MEDICAL EQUIPMENT	25% coinsurance per item when deemed medically necessary and prescribed by a Plan physician
DIABETIC SUPPLIES	25% coinsurance
LIFETIME MAXIMUM BENEFIT	25% coinsurance for office administered injectables (applies to annual out-of-pocket max). 25% coinsurance for self-administered injectables up to a max of $350 per drug per fill (does not apply to annual out-of-pocket max)
SKILLED NURSING FACILITY	25% coinsurance after deductible. Limit 100 days per benefit period
MENTAL HEALTH	
Inpatient	25% coinsurance after deductible
Outpatient	$17 copay per group visit; $35 copay per individual visit
SUBSTANCE ABUSE	
Inpatient	25% coinsurance after deductible
Outpatient	$17 copay per group visit; $35 copay per individual visit
PRESCRIPTIONS	
Retail	$15 generic, $50 brand formulary, $75 non-formulary 30-day supply. Self-administered injectables dispensed through pharmacy other than insulin and Specialty Rx 25% coinsurance up to a max of $350 per drug per fill*
Mail-Order	$30 generic, $100 brand formulary, $150 non-formulary 90-day supply. Self-administered injectables dispensed through pharmacy other than insulin and Specialty Rx 25% coinsurance up to a max of $350 per drug per fill*
Other Medical Services	
Physical Therapy	$35 copay per visit. Limit 20 visits per condition per year. ABA therapy unlimited visits.
Private Duty Nursing	25% coinsurance after deductible
Prosthetics	20% coinsurance (prosthetic arms and legs covered in accordance with state law without annual dollar limit)
Home Health Care	25% coinsurance after deductible
Vision Exams	$35 copay for optometrist; $75 copay for ophthalmologist, hardware not covered
Hearing Exams	$35 copay for exam, hardware not covered
Chiropractic Services	$15 copay per visit. Limit 20 visits per calendar year.
TMJ	Not Covered
Organ Transplants	25% coinsurance after deductible
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