# Walmart 2024
## Benefits

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| Legal Plan Name: | Kaiser Foundation Health Plan of Washington |
| Name used for associate communications: | Kaiser of Washington Low Option HMO |
| Plan State(s): | Washington |
| Customer Service Number: | 1-888-901-4636 |
| Web Address: | www.kp.org/wa |
| Active Associate Group #: | 0972100 (West and East) |
| COBRA Group #: | 0972199 (West and East) |

| BENEFIT | 2024 PLAN DESIGN |
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| DEDUCTIBLE | $1,500 individual / $3,000 family<br>Deductible does not apply to copays -- only applicable under the Welcome Waiver which is outlined in the Office Visit section |
| ANNUAL OUT-OF-POCKET MAXIMUM | $6,850 per individual / $13,700 family (includes deductible) |
| LIFETIME MAXIMUM BENEFIT | Unlimited |
| OFFICE VISITS | $30 PCP/$75 specialist. Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year |
| PREVENTIVE CARE | Covered 100% |
| MATERNITY CARE | 25% coinsurance after deductible is satisfied |
| URGENT CARE | After deductible; member pays $30 copay for primary care provider services or $75 copay for specialty care provider services and 25% coinsurance |
| TELEMEDICINE | No Charge |
| HOSPITAL CARE | |
| Inpatient | 25% coinsurance after deductible is satisfied |
| Emergency Room | 25% coinsurance after deductible is satisfied |
| Outpatient Surgery | $100 copayment per member per admission, then 25% coinsurance after deductible is satisfied |
| AMBULANCE | 20% coinsurance |
| DURABLE MEDICAL EQUIPMENT | Covered 100% |
| DIABETIC SUPPLIES | Insulin, needles, syringes & lancets covered under Prescriptions. External insulin pumps, blood glucose monitors, testing reagents & supplies covered under Durable Medical Equipment (not subject to the benefit maximum). A Member will not pay more than $35, not subject to the Deductible, for a 30-day supply of insulin to comply with state law requirements. Any cost sharing paid will apply toward the annual deductible. |
| INJECTABLES | Injections that can be self-administered are subject to the applicable prescription drug cost share |
| SKILLED NURSING FACILITY | 25% coinsurance after deductible. Limit 60 days per calendar year |
| MENTAL HEALTH | |
| Inpatient | 25% coinsurance after deductible is satisfied |
| Outpatient | $30 copay per visit; deductible and coinsurance apply. Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year. |
| SUBSTANCE ABUSE | |
| Inpatient | 25% coinsurance after deductible is satisfied |
| Outpatient | $30 copay per visit; deductible and coinsurance apply. Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year. |
| PRESCRIPTIONS | |
| Retail | Generics covered subject to the lesser of Kaiser's charge or a $10 copayment. Brand named formulary drugs covered subject to the lesser of Kaiser's charge or a $50 copayment.<br><br>Non-Formulary: Applicable Generic, Preferred brand drug cost shares. Subject to formulary guidelines, when approved through the exception process. |
| Mail-Order | Covered subject to the applicable prescription drug cost share for each 30 day supply or less. 2x prescription cost share per 90 day supply |
| Other Medical Services | |
| Physical Therapy | Outpatient: $75 copay per visit; deductible and coinsurance apply. Limit 45 visits per calendar year (combined with speech and occupational therapy services). Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year. |
| Private Duty Nursing | Covered under Inpatient Hospital Care when pre-authorized |
| Prosthetics | Covered 100% |
| Home Health Care | Covered 100% |
| Vision Exams | $30 copay per visit. $75 copay per visit (if specialist) Limit 1 exam every 12 months |
| Hearing Exams | $30 copay per visit (PCP). $75 copay per visit (Specialist - Audiologist). Deductible and coinsurance apply. Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year. |
| Chiropractic Services | $30 copay per visit; deductible and coinsurance apply. Limit 10 self-referral visits to a contracted network provider per calendar year. Deductible and Plan Coinsurance do not apply to any combination of first 4 claims received and processed for outpatient visit claims received in a calendar year. |
| TMJ | Applicable cost shares apply |
| Organ Transplants | Inpatient: Deductible and coinsurance apply |
| 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 |