# Walmart 2025
## Benefits

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| Legal Plan Name: | Kaiser Foundation Health Plan of Georgia |
| Name used for associate communications: | Kaiser Georgia Low Option HMO |
| Plan State(s): | Georgia |
| Customer Service Number: | (404) 261-2590 Atlanta Metro Area<br>(888) 865-5813 Other Areas |
| Web Address: | www.kp.org |
| Active Associate Group #: | 5578-106 |
| COBRA Group #: | 5578-107 |

| BENEFIT | 2025 PLAN DESIGN |
|---|---|
| DEDUCTIBLE | $1,500 individual / $3,000 family per calendar year |
| 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 |
| 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 | $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 (after deductible) per item when deemed medically necessary and prescribed by a Plan physician in accordance with DME formulary guidelines |
| DIABETIC SUPPLIES | Applicable Rx copay for 30 day supply (G/B/NPB/Sp) |
| INJECTABLES | Covered at 100% ($35/$75 office visit copay may apply) |
| 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 per group visit |
| SUBSTANCE ABUSE | |
| Inpatient | 25% coinsurance after deductible |
| Outpatient | $35 copay per individual therapy visit / $17 per group visit |
| PRESCRIPTIONS | |
| Retail | $10 generic, $50 brand name formulary, $75 brand name non-formulary, up to a 30 day supply<br>Specialty Rx: 25% coinsurance to a maximum of $350 |
| Mail-Order | $20 generic, $100 brand name formulary, $150 brand name non-formulary up to a 90 day supply<br>Specialty Rx: 25% coinsurance to a maximum of $350 |
| Other Medical Services | |
| Physical Therapy | $75 copay ST - Limit 20 combined PT/OT visits per calendar year; Autism Spectrum benefit is: Plan pays 100%; no annual benefit maximum; limited to children up to age 21 |
| Private Duty Nursing | Not covered |
| Prosthetics | 25% coinsurance (after deductible) when medically necessary, prescribed by a plan physician, and in accordance with DME formulary guidelines |
| Home Health Care | Covered at 100%. Limit 100 visits per calendar year |
| Vision Exams | $75 copay per visit |
| Hearing Exams | $75 copay per visit |
| Chiropractic Services | $15 copay per visit. Limit 20 visits per calendar year<br>(alignment across regions) |
| TMJ | 25% coinsurance after deductible for surgery. Etiology must be medical not dental. Non-surgical treatment such as splints and appliances 25% coinsurance after deductible |
| 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 |