Walmart 2024
Benefits

Legal Plan Name: Kaiser Foundation Health Plan of Oregon
Name used for associate communications: Kaiser of Oregon Low Option HMO
Plan State(s): Oregon
Customer Service Number: (503) 813-2000 Portland Area
(800) 813-2000 Other Areas
Web Address: www.kp.org
Active Associate Group #: 18259-003
COBRA Group #: 18259-004

BENEFIT	2024 PLAN DESIGN
DEDUCTIBLE	$1,500 per individual and $3,000 per family Deductible does not apply to copays
ANNUAL OUT-OF-POCKET MAXIMUM	$6,850 per individual / $13,700 family (includes deductible)
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	PCP: $5 copay for first 3 visits per year (then $35 copay per visit)/Specialist: $60 copay per visit/Urgent Care: $60 copay
PREVENTIVE CARE	Covered 100%
MATERNITY CARE	25% coinsurance after deductible for hospital admission; contact Plan for cost sharing on outpatient maternity office visits
URGENT CARE	$60 copay per visit
TELEMEDICINE	No Charge
HOSPITAL CARE	
Inpatient	25% coinsurance after deductible is met
Emergency Room	25% coinsurance after deductible is met
Outpatient Surgery	25% coinsurance after deductible is met
AMBULANCE	25% coinsurance after deductible is met
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	$10 for 30-day supply (see Rx benefit)
INJECTABLES	Office administered medication, including injections (all outpatient settings) 20% coinsurance after deductible
SKILLED NURSING FACILITY	25% coinsurance after deductible is met. Limit 100 days per benefit period
MENTAL HEALTH	
Inpatient	25% coinsurance after deductible is met
Outpatient	$5 copay for first 3 visits per year (then $35 copay per individual visit); $17 copay per group visit
SUBSTANCE ABUSE	
Inpatient	25% coinsurance after deductible is met
Outpatient	$5 copay for first 3 visits per year (then $35 copay per individual visit); $17 copay per group visit
PRESCRIPTIONS	Formulary Applies
Retail	$10 generic, $50 brand, $75 Non-Formulary Brand, up to a 30-day supply; Specialty Rx: 25% coinsurance to a maximum of $350
Mail-Order	$20 generic, $100 brand, $150 Non-Formulary Brand, up to a 90-day supply; Specialty Rx: 25% coinsurance to a maximum of $350
Other Medical Services	
Physical Therapy	$60 copay per visit
Private Duty Nursing	Not Covered unless medically necessary
Prosthetics	25% coinsurance when medically necessary, prescribed by a plan physician, and in accordance with DME formulary guidelines
Home Health Care	Covered 100% after deductible. Limit 100 two-hour visits per calendar year
Vision Exams	$60 copay per visit
Hearing Exams	$60 copay per visit (Audiologist)
Chiropractic Services	$15 copay per visit. Limit 20 visits per calendar year.
TMJ	25% coinsurance after deductible for surgery. Etiology must be medical not dental
Organ Transplants	25% coinsurance after deductible is satisfied
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