Walmart 2025
Benefits

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	2025 PLAN DESIGN
DEDUCTIBLE	$1,500 individual / $3,000 family 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. 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. 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
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