

**Walmart 2021
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
 (888) 681-7878 Southern Colorado
 (800) 632-9700 Other Areas
 Web Address: www.kp.org
 Active Associate Group #: 22336 - 105, 106, 113, 117
 COBRA Group #: 22336 - 109, 110, 115, 119

BENEFIT	2021 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 (alignment across regions)
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