

**Walmart 2021
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	2021 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. First four visits covered subject to the applicable outpatient services copayment. Subsequent visits covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
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 Emergency Room Outpatient Surgery	25% coinsurance after deductible is satisfied 25% coinsurance after deductible is satisfied \$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)
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 Outpatient	25% coinsurance after deductible is satisfied \$30 copay per visit; deductible and coinsurance apply
SUBSTANCE ABUSE Inpatient Outpatient	25% coinsurance after deductible is satisfied \$30 copay per visit; deductible and coinsurance apply
PRESCRIPTIONS Retail Mail-Order	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. 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)
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
Chiropractic Services	\$30 copay per visit; deductible and coinsurance apply. Limit 10 self-referral visits to a contracted network provider per 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