Walmart 2026
Benefits

Legal Plan Name:	Health Net Salud y Mas California
Name used for associate communications:	Health Net Salud y Mas HMO
Plan State(s):	California
Customer Service Number:	1-800-722-5342
Web Address:	www.healthnet.com
Active Associate Group #:	L6408A
COBRA Group #:	L6408C

BENEFIT	2026 PLAN DESIGN	2026 PLAN DESIGN CA Members with Self Referral to Providers in Mexico
DEDUCTIBLE	None	None
ANNUAL OUT-OF-POCKET MAXIMUM*	$6,850 per individual / $13,700 per family	$1,500 individual, $3,000 two party, $4,500 family (combined)
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited
OFFICE VISITS	$35 PCP; $75 specialist copay per visit	$10 copay per visit
PREVENTIVE CARE	Covered 100%	Covered 100% (Women's preventive health copays will be waived)
MATERNITY CARE	$1,000 copay* + 25% coinsurance (until OOPM is met) for hospital admission; outpatient office visits for maternity covered at 100%	Covered at 100%
URGENT CARE	$15 copay	$10 copay
TELEMEDICINE	No charge through Health Net's preferred telehealth provider; office copay applies for telehealth services provided by the member's medical group	Not Covered
HOSPITAL CARE		
Inpatient	$1,000 copay* + 25% coinsurance (until OOPM is met)	Covered at 100%
Emergency Room	25% coinsurance (waived if admitted)	$10 copay per visit (waived if admitted)
Outpatient Surgery	$1,000 copay* + 25% coinsurance (until OOPM is met)	Covered at 100%
AMBULANCE	$100 copay per transport	No charge Air ambulance is not covered
DURABLE MEDICAL EQUIPMENT	No charge	No charge
DIABETIC SUPPLIES	Diabetic supplies (blood glucose testing strips, disposable needles and syringes) and insulin are subject to the brand name (tier 2 formulary) or with PA non-formulary (tier 3) copays/coinsurance. Brand name copay is $50 and non-formulary is 50% retail. $250/script max	Covered at 100% for the medical benefit such as blood glucose monitor, visual aids (except eyewear), diabetic footwear etc. Diabetic supplies that require a prescription from the physician are subject to the pharmacy benefit copays such as the blood glucose test strips or insulin. Pharmacy benefit copay $5
INJECTABLES	Office based injectable medication (per dose) Covered at 100%. Self injectable drugs (up to a 30 day prescription) covered at $0 copay	Covered at 100%
SKILLED NURSING FACILITY	$1,000 copay* + 25% coinsurance (until OOPM is met). Limited to 100 days a calendar year	Covered at 100%. Limited to 100 days a calendar year
MENTAL HEALTH		
Inpatient	$1,000 copay* + 25% coinsurance (until OOPM is met). Partial hospitalization 100% covered	Covered at 100%
Outpatient	$35 copay per visit, unlimited visits /$17.50 per group therapy visit	$10 copay, unlimited visits
SUBSTANCE ABUSE		
Inpatient	$1,000 copay* + 25% coinsurance (until OOPM is met). Partial hospitalization 100% covered	Covered at 100%
Outpatient	$35 copay per visit, unlimited visits /$17.50 per group therapy visit	$10 copay, unlimited visits
PRESCRIPTIONS		
Retail	$10 generic, $50 brand name. Tier 3 coverage for medically necessary only. Prior authorization and step therapy applies. 50% non-formulary copay per prescription with $250 per script max	$5 per prescription. Prescriptions must be filled at a SIMNSA participating pharmacy
Mail-Order	$20 generic, $100 brand name. Tier 3 coverage for medically necessary only. Prior authorization and step therapy applies. 50% non-formulary copay per prescription with $750 per script max	Not covered
Other Medical Services		
Physical Therapy	$35 copay per visit	$10 copay per visit
Private Duty Nursing	Not covered	Not covered
Prosthetics	Covered at 100%; guidelines apply	Covered at 100%; guidelines apply
Home Health Care	$35 copay per visit; limit 100 visits per calendar year	Not covered
Vision Exams	$35 copay per visit. 100% if preventive	$10 copay per visit
Hearing Exams	$35 copay per visit. 100% if preventive	$10 copay per visit
Chiropractic Services	$15 copay per visit. Limit 20 visits per calendar year. No referral necessary. Chiropractic service is administered by American Specialty Health	Not covered
TMJ	$35 copay PCP/$75 copay specialist; guidelines apply	$10 copay per office visit; guidelines apply
Organ Transplants	Professional services are covered 100%, inpatient copay will apply	Covered at 100%
The following applies to the out-of-pocket maximum	All covered 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	

* The $1,000 copayment is combined with Inpatient Hospital, Outpatient Surgery, Inpatient Maternity Care, Skilled Nursing Facility, Inpatient Mental Health, and is required once each calendar year. 25% coinsurance will continue to apply until the Out-of-Pocket maximum is satisfied.