

**Walmart 2026
Benefits**

Legal Plan Name: Kaiser Foundation Health Plan of Georgia
Name used for associate communications: Kaiser Georgia Low Option HMO
Plan State(s): Georgia
Customer Service Number: (404) 261-2590 Atlanta Metro Area
(888) 865-5813 Other Areas
Web Address: www.kp.org
Active Associate Group #: 5578-106
COBRA Group #: 5578-107

BENEFIT	2026 PLAN DESIGN
DEDUCTIBLE	\$1,500 individual / \$3,000 family per calendar year
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
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	\$35 copay per visit
TELEMEDICINE	No Charge
HOSPITAL CARE Inpatient Emergency Room Outpatient Surgery	25% coinsurance after deductible 25% coinsurance after deductible 25% coinsurance after deductible
AMBULANCE	25% coinsurance after deductible
DURABLE MEDICAL EQUIPMENT	25% coinsurance (after deductible) 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) Applicable Rx copay for 30 day supply (G/B/NPB/Sp)
INJECTABLES	Covered at 100% (\$35/\$75 office visit copay may apply)
SKILLED NURSING FACILITY	25% coinsurance after deductible. Limit 100 days per benefit period
MENTAL HEALTH Inpatient Outpatient	25% coinsurance after deductible \$35 copay per individual therapy visit / \$17 per group visit
SUBSTANCE ABUSE Inpatient Outpatient	25% coinsurance after deductible \$35 copay per individual therapy visit / \$17 per group visit
PRESCRIPTIONS Retail Mail-Order	\$10 generic, \$50 brand name formulary, \$75 brand name non-formulary, up to a 30 day supply Specialty Rx: 25% coinsurance to a maximum of \$350 \$20 generic, \$100 brand name formulary, \$150 brand name non-formulary up to a 90 day supply Specialty Rx: 25% coinsurance to a maximum of \$350
Other Medical Services	
Physical Therapy	\$75 copay per visit. Limit 20 combined PT/OT visits per calendar year; (ABA children up to age 21, unlimited visits, no annual benefit maximum)
Private Duty Nursing	Not covered
Prosthetics	25% coinsurance (after deductible) when medically necessary, prescribed by a plan physician, and in accordance with DME formulary guidelines
Home Health Care	Covered at 100%. Limit 100 visits per calendar year
Vision Exams	\$75 copay per visit
Hearing Exams	\$75 copay per visit
Chiropractic Services	\$15 copay per visit. Limit 20 visits per calendar year (alignment across regions)
TMJ	25% coinsurance after deductible for surgery. Etiology must be medical not dental. Non-surgical treatment such as splints and appliances 25% coinsurance after deductible
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