

State of Colorado - Copay Basic Plan

One KPCO

Deductible/Coinsurance HMO

DHMO \$1,500 / 20% coinsurance

Group Number: 225

Effective Date: 7/1/2023 - 6/30/2024

Non-Grandfathered

General Information	
Website	www.KP.org
Member Services Number	One KPCO: 1-800-632-9700
Member Services Weekday Hours	8:00 a.m. to 6:00 p.m.
Member Services Weekend Hours	Closed on Weekends
Medical Information	Benefit Plan Design
Contract Year Deductible: Individual/Family	\$1,250 / \$2,500
Contract Year Out-of-Pocket Maximum: Individual/Family	\$4,500 / \$9,000
Is the deductible included in the out-of-pocket maximum?	Yes For Families, the individual family members are responsible for meeting the Family Out-of-Pocket (OPM), only up to the Individual OPM amount.
Office Visits (Outpatient)	
Primary Care	\$20 copay each primary care office visit 20% coinsurance for procedures received during an office visit after deductible is met
Specialty Care	\$40 copay each specialist care office visit 20% coinsurance for procedures received during an office visit after deductible is met
Office Administered Drugs	20% coinsurance after deductible is met
Preventive Care	No charge each preventive care office visit
Prenatal Care	20% coinsurance each routine prenatal care visit after deductible is met Routine prenatal care visits will be charged after delivery
Well-Child Care (17 years or younger)	No charge each well-child care office visit
Physical, Occupational, Speech Therapy (Outpatient)	\$20 copay each visit for up to 20 visits per year for each type of therapy
Outpatient/Ambulatory Surgery	20% coinsurance
Hospital Care (Inpatient)	
Inpatient	20% coinsurance after deductible is met
Delivery and Inpatient Baby Care	20% coinsurance after deductible is met
Physical, Occupational, Speech Therapy (Inpatient)	20% coinsurance after deductible is met up to 60 days per year
Emergency Care	
Ambulance	20% coinsurance up to \$500 per trip
Emergency Room	20% coinsurance Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately

IMPORTANT: This synopsis is not a contract with Kaiser Permanente. It only briefly summarizes the benefits in the Agreement between Kaiser Permanente and your group. Please consult your Evidence of Coverage for complete details of benefits as well as exclusions and limitations. In the event of ambiguity and/or conflict between this synopsis and your Evidence of Coverage, the Evidence of Coverage shall control.

Emergency Care (cont.)	
Urgent Care	\$75 copay each visit at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area 20% coinsurance for procedures received during an office visit after deductible is met
Lab and X-Ray	
Laboratory	100% covered at a Plan Medical Office or in a contracted free-standing facility 20% coinsurance after deductible is met for services at a Plan Hospital
X-Ray	Diagnostic X-rays: 20% coinsurance after deductible is met Therapeutic X-rays: 20% coinsurance after deductible is met
Special Procedures: MRI/CT/PET/Nuclear Medicine	20% coinsurance after deductible is met
Mental Health and Chemical Dependency	
Mental Health Outpatient	\$0 copay each office visit
Mental Health Inpatient	20% coinsurance per admission after deductible is met
Chemical Dependency Outpatient	\$0 copay each office visit
Chemical Dependency Inpatient Medical Detoxification	20% coinsurance after deductible is met Detoxification is limited to removing toxic substance from the body
Chemical Dependency Inpatient Residential Rehabilitation	20% coinsurance after deductible is met
Prescription Drugs	
Prescription Deductible	None
Retail: Generic	\$7 copay
Retail: Brand	\$30 copay
Retail: Non-Preferred	\$60 copay
Retail: Day Supply	Up to a 30 day supply
Mail Order	Mail order drugs are available for up to a 90 day supply for two copayments Certain drugs limited to a 30 day supply Prescriptions for second and on-going maintenance medications must be filled at a pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente Mail Order
Specialty Drugs Including Self-Injectables	20% coinsurance up to a maximum of \$120 per drug dispensed
Other	
Skilled Nursing Facility	20% coinsurance up to 100 days per calendar year after deductible is met Not covered outside the Service Area
Hospice Care	No charge; Not covered outside the Service Area
Home Health Care	20% coinsurance after deductible is met for prescribed medically necessary part-time home health services; Not covered outside the Service Area
Durable Medical Equipment	20% coinsurance after deductible is met Prosthetic arms and legs covered at 20% coinsurance (no annual maximum benefit) See policy for types and circumstances of coverage
Hearing Care	\$20 copay; \$1,000 credit per ear every 36 months Hearing aid coverage available to children under 18; limitations apply
Chiropractic Care	\$50 copay up to 20 visits per contract year
Acupuncture	\$50 copay up to 20 visits per contract year
Vision Care	\$20 copay ; members age 19 and over \$150 credit towards optical hardware, members up to the end of the month he/she turns 19 20% Coinsurance towards optical hardware every 24 months
Active & Fit	Not Covered
First Responder	Not Covered