

State of Colorado

High Deductible/Coinsurance HMO

HDHP \$1,750 / 25% coinsurance

Effective Date: 07/01/2024 - 6/30/2025

One KPCO

Group Number: 225

Non-Grandfathered

| General Information | |
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| 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 | \$1,750 / \$3,500 |
| Contract Year Out-of-Pocket Maximum: Individual/Family | \$5,000 / \$8,000 / \$10,000 Embedded |
| Is the deductible included in the out-of-pocket maximum? | Yes |
| Embedded Deductible and Out-of-Pocket Maximum: | 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 | 25% coinsurance each primary care office visit after deductible is met |
| Specialty Care | 25% coinsurance each specialist care office visit after deductible is met |
| Office Administered Drugs | 25% coinsurance after deductible is met |
| Preventive Care | No charge each preventive care office visit |
| Prenatal Care | 25% coinsurance each routine prenatal care visit after deductible is met |
| Well-Child Care (17 years or younger) | No charge each well-child care office visit |
| Physical, Occupational, Speech Therapy (Outpatient) | 25% coinsurance each visit for up to 20 visits per year for each type of therapy after deductible is met |
| Outpatient/Ambulatory Surgery | 25% coinsurance after deductible is met |
| Hospital Care (Inpatient) | |
| Inpatient | 25% coinsurance after deductible is met |
| Delivery and Inpatient Baby Care | 25% coinsurance after deductible is met |
| Physical, Occupational, Speech Therapy (Inpatient) | 25% coinsurance after deductible is met up to 60 days per year |
| Emergency Care | |
| Ambulance | 25% coinsurance after deductible is met |
| Emergency Room | 25% coinsurance after deductible is met Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately |
| Emergency Care (Cont.) | |
| Urgent Care | 25% coinsurance each visit after deductible is met at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area |

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.

| Lab and X-Ray | |
|--|---|
| Laboratory | 25% coinsurance after deductible is met at a Plan Medical Office or in a contracted free-standing facility |
| X-Ray | Diagnostic X-rays: 25% coinsurance after deductible is met Therapeutic X-rays: 25% coinsurance after deductible is met |
| Special Procedures: MRI/CT/PET/Nuclear Medicine | 25% coinsurance after deductible is met |
| Mental Health and Chemical Dependency | |
| Mental Health Outpatient | 25% coinsurance each office visit after deductible is met |
| Mental Health Inpatient | 25% coinsurance after deductible is met |
| Chemical Dependency Outpatient | 25% coinsurance each office visit after deductible is met |
| Chemical Dependency Inpatient Medical Detoxification | 25% coinsurance after deductible is met Detoxification is limited to removing toxic substance from the body |
| Chemical Dependency Inpatient Residential Rehabilitation | 25% coinsurance after deductible is met |
| Prescription Drugs | |
| Prescription Deductible | Medical annual deductible applies |
| Retail: Generic | \$10 copay after deductible is met |
| Retail: Brand | \$40 copay after deductible is met |
| Retail: Non-Preferred | \$60 copay after deductible is met |
| Retail: Day Supply | Up to a 30 day supply |
| Mail Order | Mail order drugs are available for up to a 90 day supply after deductible is met 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 after deductible is met |
| Other | |
| Skilled Nursing Facility | 25% coinsurance up to 100 days per calendar year after deductible is met Not covered outside the Service Area |
| Hospice Care | 25% coinsurance after deductible is met Not covered outside the Service Area |
| Home Health Care | 25% coinsurance after deductible is met for prescribed medically necessary part-time home health services Not covered outside the Service Area |
| Durable Medical Equipment | 25% coinsurance after deductible is met Prosthetic arms and legs covered at 20% coinsurance after deductible is met no annual maximum benefit. See policy for types and circumstances of coverage. |
| Hearing Care | 25% coinsurance after deductible is met; \$1,000 credit per ear every 36 months Hearing aid coverage available to children under 18; limitations apply |
| Chiropractic Care | 25% coinsurance after deductible is met up to 20 visits per contract year |
| Acupuncture | 25% coinsurance after deductible is met up to 20 visits per contract year |
| Vision Care | 25% coinsurance after deductible is met; members age 19 and over \$150 credit towards optical hardware, members up to the end of the month he/she turns 19 25% Coinsurance towards optical hardware every 24 months, |
| Active & Fit | Not Covered |
| First Responder | Not Covered |