KAISER PERMANENTE®

State of Colorado - Copay Plus Plan

Deductible/Coinsurance HMO

DHMO $750 / 20% coinsurance

Effective Date: 7/1/2024 - 6/30/2025

Colorado Region Service Areas:

One KPCO

Group Number: 225

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	$750 / $2,000
Contract Year Out-of-Pocket Maximum: Individual/Family	$3,500 / $7,000
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	$1,000 copay Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately

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 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	$10 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