KAISER PERMANENTE®

University of Denver

Deductible/Coinsurance HMO

DHMO $0 20% Plus

Effective Date: 07/01/2024 - 12/31/2025

Colorado Region Service Areas:

One KPCO

Group Number: 00214

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**
Calendar Year Deductible: Individual/Family	N/A
Calendar Year Out-of-Pocket Maximum: Individual/Family	$2,000 / $4,500
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	$25 copay each primary care office visit
Specialty Care	$40 copay each specialist care office visit
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)	$25 copay each visit for up to 20 visits per year for each type of therapy after deductible is met
Outpatient/Ambulatory Surgery	10% coinsurance if received in a Plan Ambulatory Surgery Center (ASC) , 20% coinsurance after deductible is met if received in the Outpatient Department of a Plan Hospital (HOSC)
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 per trip after deductible is met
Emergency Room	20% coinsurance after deductible is met Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately

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Emergency Care (cont.)	
Urgent Care	$50 copay each visit at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area
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: No charge Therapeutic X-rays: No charge
Special Procedures: MRI/CT/PET/Nuclear Medicine	$100 copay
Mental Health and Chemical Dependency	
Mental Health Outpatient	$25 copay each office visit
Mental Health Inpatient	20% coinsurance per admission after deductible is met
Chemical Dependency Outpatient	$25 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	$15 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 $75 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	No charge 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	$25 copay ; hardware not covered Hearing aid coverage available to children under 18; limitations apply
Chiropractic Care	$25 copay up to 20 visits
Acupuncture	Not covered
Vision Care	$25 copay; hardware not covered
Active & Fit	Not Covered
First Responder	Not Covered

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DHMO Plus Benefits				
Maximum Benefit per Individual per Calendar Year	20 combined total visits			
Primary Care Visit	$40 copay each primary care office visit 30% coinsurance for procedures received during an office visit			
Specialty Care Visit	$60 copay each specialist care office visit 30% coinsurance for procedures received during an office visit			
Laboratory	30% coinsurance for services at a non-Plan Office or Free Standing Facility (each Laboratory service per provider per day is considered a visit)			
X-Ray (Diagnostic Only)	30% coinsurance (each X-Ray is considered a visit)			
Special Procedures: MRI/CT/PET/Nuclear Medicine	Not Covered			
Mental Health Outpatient	$40 copay each office visit 30% coinsurance for procedures received during an office visit			
Chemical Dependency Outpatient	$40 copay each office visit 30% coinsurance for procedures received during an office visit			
Physical, Occupational, Speech Therapy (Outpatient)	$40 copay each visit at a Non-Plan Office or Free Standing Site			
Preventive and Well-Child Care	No charge each office visit			
Durable Medical Equipment (provided by office, Supplemental only)	30% coinsurance Prosthetic arms and legs are not covered (each item dispensed during office visit is considered a visit)			
Prescription Drugs	Limited to 10 Prescription Fills Prescription drugs from non-Kaiser Permanente physicians will be covered when filled at a Kaiser Permanente pharmacy at your regular Plan prescription drug cost share, subject to the Kaiser Permanente formulary. This will not count toward the combined total visit limit. When filled in a non-Kaiser Permanente pharmacy, retail prescription drugs are covered up to a 30-day supply.			
	Generic Drugs: 50% coinsurance	Brand Drugs: 50% coinsurance	Non-Preferred Drugs: 50% coinsurance	Specialty Drugs: 50% coinsurance
Notes:				

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