KAISER PERMANENTE®

University of Denver

High Deductible/Coinsurance HMO

HDHP $1600 AGG 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	$1,600 / $3,200
Calendar Year Out-of-Pocket Maximum: Individual/Family	$3,200 / $6,400
Is the deductible included in the out-of-pocket maximum?	Yes
Aggregate Deductible and Out-of-Pocket Maximum:	For family memberships, the Individual Deductible and Out-of-Pocket Maximum (OPM) do not apply. The Family Deductible and OPM can be met by one family member or by a combination of family members.
Office Visits (Outpatient)	
Primary Care	20% coinsurance each primary care office visit after deductible is met
Specialty Care	20% coinsurance each specialist care 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
Well-Child Care (17 years or younger)	No charge each well-child care office visit
Physical, Occupational, Speech Therapy (Outpatient)	20% coinsurance 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 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

Emergency Care (cont.)

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Urgent Care	20% coinsurance each visit after deductible is met at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area
Lab and X-Ray	
Laboratory	20% coinsurance after deductible is met at a Plan Medical Office or in a contracted free-standing facility
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	20% coinsurance each office visit after deductible is met
Mental Health Inpatient	20% coinsurance after deductible is met
Chemical Dependency Outpatient	20% coinsurance each office visit after deductible is met
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	Medical annual deductible applies
Retail: Generic	$15 copay after deductible is met
Retail: Brand	$30 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 $75 per drug dispensed after deductible is met
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	20% coinsurance after deductible is met 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 after deductible is met no annual maximum benefit. See policy for types and circumstances of coverage.
Hearing Care	20% coinsurance after deductible is met; hardware not covered Hearing aid coverage available to children under 18; limitations apply
Chiropractic Care	20% coinsurance up to 20 visits
Acupuncture	Not covered
Vision Care	20% coinsurance after deductible is met; ; hardware not covered
Active & Fit	Not Covered
First Responder	Not Covered

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Colorado Region Service Areas:

HDHP Plus Benefits				
Maximum Benefit per Individual per Calendar Year	20 combined total visits			
Primary Care Visit	20% coinsurance after deductible is met			
Specialty Care Visit	20% coinsurance after deductible is met			
Laboratory	20% 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)	20% coinsurance (each X-Ray is considered a visit)			
Special Procedures: MRI/CT/PET/Nuclear Medicine	Not Covered			
Mental Health Outpatient	20% coinsurance after deductible is met			
Chemical Dependency Outpatient	20% coinsurance after deductible is met			
Physical, Occupational, Speech Therapy (Outpatient)	20% coinsurance after deductible is met 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)	20% 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 .			
	Generic Drugs: 50% coinsurance	Brand Drugs: 50% coinsurance	Non-Preferred Drugs: 50% coinsurance	Specialty Drugs: 50% coinsurance
Notes:				

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