KAISER PERMANENTE®

Denver Solutions LLC

Deductible/Coinsurance HMO

DHMO $250 / 20% coinsurance

Effective Date: 1/1/2022 - 12/31/2022

Colorado Region Service Areas:

One KPCO

Group Number: 37470

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	$250 / $500
Calendar Year Out-of-Pocket Maximum: Individual/Family	$500 / $1,500
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	$15 copay each primary care office visit 20% coinsurance for procedures received during an office visit after deductible is met
Specialty Care	$30 copayeach 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)	$15 copay each visit for up to 20 visits per year for each type of therapy
Outpatient/Ambulatory Surgery	$500 copay 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 up to $500 per trip
Emergency Room	$300 copay 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	$50 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	$100 copay
Mental Health and Chemical Dependency	
Mental Health Outpatient	$15 copay each office visit 20% coinsurance for procedures received during an office visit after deductible is met
Mental Health Inpatient	20% coinsurance per admission after deductible is met
Chemical Dependency Outpatient	$15 copay each office visit 20% coinsurance for procedures received during an 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	None
Retail: Generic	$10 copay
Retail: Brand	$30 copay
Retail: Non-Preferred	$50 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 $250 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	$15 copay; hardware not covered Hearing aid coverage available to children under 18; limitations apply
Chiropractic Care	Not covered
Acupuncture	Not covered
Vision Care	$15 copay; hardware not covered
Active & Fit	Not Covered
First Responder	Not Covered