KAISER PERMANENTE®

Academy School District 20

KP Select: Deductible/Coinsurance HMO

DHMO Select DHMO 4000/8000 30%

Effective Date: 7/1/2018 -6/30/2019

Colorado Region Service Areas:

Colorado Springs

Group Number: 49023

Non-Grandfathered

General Information	
Website	www.KP.org
Member Services Number	Southern Colorado: 1-888-681-7878
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	$4,000 / $8,000
Contract Year Out-of-Pocket Maximum: Individual/Family	$6,000 / $12,000
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	$40 copay each primary care office visit 30% coinsurance for procedures received during an office visit after deductible is met
Specialty Care	$60 copay each specialist care office visit 30% coinsurance for procedures received during an office visit after deductible is met
Office Administered Drugs	30% coinsurance after deductible is met
Preventive Care	No charge each preventive care office visit
Prenatal Care	30% 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)	$40 copay each visit for up to 20 visits per year for each type of therapy
Outpatient/Ambulatory Surgery	$500 copay if performed in a non-hospital outpatient facility; 30% coinsurance if performed in a hospital outpatient facility after deductible is met
Hospital Care (Inpatient)	
Inpatient	30% coinsurance after deductible is met
Delivery and Inpatient Baby Care	30% coinsurance after deductible is met
Physical, Occupational, Speech Therapy (Inpatient)	30% coinsurance after deductible is met up to 60 days per year
Emergency Care	
Ambulance	30% coinsurance up to $500 per trip
Emergency Room	$350 copay; Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately
Urgent Care	$100 copay at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area; Special Procedures (see Lab and X-Ray) performed in the urgent care facility will be charged separately

Lab and X-Ray	
Laboratory	No charge if during office visit at a Plan Medical Office; $40 copay at a non-hospital outpatient facility; 30% coinsurance after deductible is met at a hospital outpatient facility
X-Ray	$40 copay at a non-hospital outpatient facility; 30% coinsurance after deductible is met at a hospital outpatient facility
Special Procedures: MRI/CT/PET/Nuclear Medicine	$300 copay at a non-hospital outpatient facility; 30% coinsurance after deductible is met at a hospital outpatient facility
Mental Health and Chemical Dependency	
Mental Health Outpatient	$40 copay each office visit 30% coinsurance for procedures received during an office visit after deductible is met
Mental Health Inpatient	30% coinsurance after deductible is met
Chemical Dependency Outpatient	$40 copay each office visit 30% coinsurance for procedures received during an office visit after deductible is met
Chemical Dependency Inpatient Medical Detoxification	30% coinsurance after deductible is met Detoxification is limited to removing toxic substance from the body
Chemical Dependency Inpatient Residential Rehabilitation	30% coinsurance after deductible is met
Prescription Drugs	
Prescription Deductible	None
Retail: Generic	$20 copay
Retail: Brand	$50 copay
Retail: Non-Preferred	$75 copay
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 $250 per drug dispensed
Other	
Skilled Nursing Facility	30% coinsurance up to 100 days per contract year after deductible is met Not covered outside the Service Area
Hospice Care	No charge Not covered outside the Service Area
Home Health Care	30% coinsurance after deductible is met for prescribed medically necessary part-time home health services Not covered outside the Service Area
Durable Medical Equipment	30% 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	$40 copay; hardware not covered Hearing aid coverage available to children under the age 18; limitations apply
Chiropractic Care	Not covered
Vision Care	$40 copay; hardware not covered