KAISER PERMANENTE®: OnePoint HRO DHMO 1000

Coverage for: Individual/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 Individual / $3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive services, certain services with copays, prescription drugs and hospice	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$4,000 Individual / $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible.
	Specialist visit	$50 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: No Charge	Not Covered	Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; 20% Coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: $10 Copay; Mail Order: $20 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: $40 Copay; Mail Order: $80 Copay	Not Covered	
	Non-preferred brand drugs	Retail: $75 Copay; Mail Order: $150 Copay	Not Covered	
	Specialty drugs	20% Coinsurance up to $250 per drug dispensed retail and mail order prescriptions	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit	$250 Copay per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
				waived if admitted directly to the hospital as an inpatient. Copay not subject to deductible.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Not subject to deductible.
	Urgent care	$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Group visit 50% of individual visit copay. Copay not subject to deductible.
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: $25 Copay per visit	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.
	Habilitation services	$25 Copay per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance. Not subject to deductible.
	Hospice services	No Charge	Not Covered	Not subject to deductible.
If your child needs dental or eye care	Children's eye exam	$25 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	For services with an ophthalmologist see "Specialist visit". Copay not subject to deductible.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
-
- Chiropractic care
- Cosmetic Surgery
- Hearing aids with limits (Adults)
-
- Long Term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Routine Dental Services
-
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

-
- Bariatric surgery
-
- Hearing aids with limits
- Infertility treatment
- Private-Duty Nursing
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.
See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist *[copay]*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$30
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,190

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist *[copay]*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,060

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist *[copay]*	$50
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**)تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị.
Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-632-9700 (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	OnePoint HRO DHMO 1000
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available **only** in the following counties as determined by **zip code** and employer service area selection: 1. **For Denver/Boulder service area:** Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. **For Southern Colorado:** Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. **For Southern Colorado *KP Select Plan***: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. **For Northern Colorado:** Adams, Larimer, Morgan, and Weld; 5. **For Mountain Colorado:** Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments for Essential Health Benefits.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA)

USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
10. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874 Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

KAISER PERMANENTE®

OnePoint HRO

Deductible/Coinsurance HMO

DHMO 1000 20%

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

Colorado Region Service Areas:

Denver/Boulder, Southern Colorado, Northern Colorado, and Mountain Colorado

Group Number: 35927

Non-Grandfathered

General Information	
Website	www.KP.org
Member Services Number	Denver/Boulder: 1-800-632-9700; Southern Colorado: 1-888-681-7878; Northern Colorado: 1-844-201-5824; Mountain Colorado: 1-844-837-6884
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	$1,000 / $3,000
Calendar Year Out-of-Pocket Maximum: Individual/Family	$4,000 / $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	$25 copay each primary care office visit 20% coinsurance for procedures received during an office visit after deductible is met
Specialty Care	$50 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)	$25 copay each visit for up to 20 visits per year for each type of therapy
Outpatient/Ambulatory Surgery	20% coinsurance after deductible is met
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	$250 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	$25 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	$25 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	$40 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 for two copayments Certain drugs limited to a 30 day supply For Southern Colorado members: 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	$25 copay ; hardware not covered Hearing aid coverage available to children under the age 18; limitations apply
Chiropractic Care	Not covered
Acupuncture	Not covered
Vision Care	$25 copay ; hardware not covered