

University of Denver

One KPCO

Deductible/Coinsurance HMO

DHMO \$250 / 20% coinsurance

Group Number: 214

Effective Date: 01/01/2026 - 12/31/2026

Non-Grandfathered

General Information	
Website	www.KP.org
Member Services Number	One KPCO: 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
Calendar Year Deductible: Individual/Family	\$250 / \$500
Calendar Year Out-of-Pocket Maximum: Individual/Family	\$3,000 / \$6,000
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
Specialty Care	\$50 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
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

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	\$75 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 \$300 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 after deductible is met (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	Not covered
Acupuncture	Not covered
Vision Care	\$25 copay; hardware not covered
Active & Fit	Not Covered
First Responder	Not Covered

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:				