

Okta, Inc.

One KPCO

Traditional HMO

HMO 20

Group Number: 47106

Effective Date: 1/1/2021 - 12/31/2021

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	Not Applicable
Calendar Year Out-of-Pocket Maximum: Individual/Family	\$1,500 / \$3,000 For Families, the individual family members are responsible for meeting the Family OPM, only up to the Individual OPM amount.
Office Visits (Outpatient)	
Primary Care	\$20 copay each primary care office visit
Specialty Care	\$20 copay each specialist care office visit
Office Administered Drugs	20% coinsurance
Preventive Care	No charge each preventive care office visit
Prenatal Care	No charge each routine prenatal care visit
Well-Child Care (17 years or younger)	No charge each well-child care office visit
Physical, Occupational, Speech Therapy (Outpatient)	\$20 copay each visit for up to 20 visits per year for each type of therapy
Outpatient/Ambulatory Surgery	\$20 copay
Hospital Care (Inpatient)	
Inpatient	\$0 copay per admission
Delivery and Inpatient Baby Care	\$0 copay per admission
Physical, Occupational, Speech Therapy (Inpatient)	\$0 copay per admission up to 60 days per year
Emergency Care	
Ambulance	\$50 copay per trip
Emergency Room	\$250 copay Special Procedures (see Lab and X-Ray) performed in the Emergency Room will be charged separately
Urgent Care	\$20 copay each visit at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area

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.

Lab and X-Ray	
Laboratory	100% covered at a Plan Medical Office or in a contracted free-standing facility
X-Ray	Diagnostic X-rays: No charge Therapeutic X-rays: \$0 copay
Special Procedures: MRI/CT/PET/Nuclear Medicine	\$0 copay per procedure/scan
Mental Health and Chemical Dependency	
Mental Health Outpatient	\$20 copay each office visit
Mental Health Inpatient	\$0 copay per admission
Chemical Dependency Outpatient	\$20 copay each office visit
Chemical Dependency Inpatient Medical Detoxification	\$0 copay per admission Detoxification is limited to removing toxic substance from the body
Chemical Dependency Inpatient Residential Rehabilitation	\$0 copay per admission
Prescription Drugs	
Prescription Deductible	None
Retail: Generic	\$10 copay
Retail: Brand	\$20 copay
Retail: Non-Preferred	\$35 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 copay
Other	
Skilled Nursing Facility	100% covered up to 100 days per calendar year Not covered outside the Service Area
Hospice Care	100% covered Not covered outside the Service Area
Home Health Care	100% covered for prescribed medically necessary part-time home health services Not covered outside the Service Area
Durable Medical Equipment	20% coinsurance Prosthetic arms and legs covered at 20% coinsurance (no annual maximum benefit) See policy for types and circumstances of coverage
Hearing Care	\$20 copay; hardware not covered Hearing aid coverage available to children under the age 18; limitations apply
Chiropractic Care	\$15 copay up to 30 visits per calendar year
Acupuncture	Not Covered
Vision Care	\$20 copay; hardware not covered
Active & Fit	Not Covered
First Responder	Not Covered