KAISER PERMANENTE®

33190*S8S0MBZLD000283



33190SS

PO BOX 830913
BIRMINGHAM,AL 35283-0913

0101 RETURN SERVICE REQUESTED

# Status of Deductible Plan Accumulation
## This is NOT a bill. No payment is requested.

This is a summary of amounts you have accumulated toward your individual and family deductible and out-of-pocket (OOP) maximum.

Deductible Plan

Statement Date: 12/06/2007
Subscriber Number: 0000999999

JANE JONES
123 CENTER ST
ANY CITY, CA 99999-4444

**Questions?**
Contact: Deductible Products Service Team
Hours of Operation: Monday - Friday, 7 AM to 5 PM
Phone: (800) 390-3507

*Thank you for selecting Kaiser Foundation Health Plan, Inc. for your healthcare needs.*

**Summary of Amounts Accumulated Toward Individual and Family Deductible and Out-of-Pocket (OOP) Maximum**
*01/01/07 - 12/31/07*

**Individual Deductible = $1500.00** **Individual OOP Maximum = $3500.00** **Family Deductible = $3000.00** **Family OOP Maximum = $7000.00**

| Individual Accumulation Totals | Accumulated This Period | | Accumulated Plan YTD | |
|---|---|---|---|---|
| | Deductible | OOP Max | Deductible | OOP Max |
| JANE JONES | $70.00 | $70.00 | $535.00 | $535.00 |

| Family Accumulation Totals | Deductible | OOP Max | Deductible | OOP Max |
|---|---|---|---|---|
| Accumulation Totals | $70.00 | $70.00 | $535.00 | $535.00 |

**The statement below only includes activity that accumulated towards your deductible or out-of-pocket maximum since your last statement.**

| Service Description | Service Date | Patient's Name | Reference No. | Allowed Amount | Plan Benefit | Your Liability: Accumulate Towards Deductible | Your Liability: Co-Pay | Your Liability: Co-Insurance | Your Liability: Accumulate Toward OOP Maximum | Explanation Code* |
|---|---|---|---|---|---|---|---|---|---|---|
| Medical Services | 10/23/07 | JANE JONES | 02468ABC | $70.00 | | $70.00 | | | $70.00 | K |
| **Total Accumulated Towards Deductible:** | | | | | | **$70.00** | | | | |
| **Total Accumulated Towards Out-of-Pocket Maximum:** | | | | | | | | | **$70.00** | |

** See reverse side for further information on explanation codes.*

# How to read this statement

KAISER PERMANENTE®

The Status of Deductible Plan Accumulation tells you how much you have accumulated toward your individual and family deductible and out-of-pocket (OOP) maximimum. We'll send you a statement each time there is a change in the status of your accumulation. We're including the information below to help you understand how we calculate your deductible accumulation and your out-of-pocket maximum.

## Common terms and codes

Here are some terms we use when talking about deductible products. Some of these terms are also defined in your Evidence of Coverage.

**Allowed Amount.** The maximum amount that a deductible plan member will pay for a given service.

**Annual out-of-pocket maximum (OOP max).** The maximum amount you'll pay for eligible covered services in a calendar year. For example, the total of a member's applicable deductible, most coinsurance, and most copays are limited to an annual out-of-pocket maximum of $3,000 (individual) or $6,000 (family). Once you have reached that maximum, you won't have to pay any copayments, deductibles, or coinsurance for those covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum.

**Coinsurance.** The percentage of charges, as defined by your *Evidence of Coverage,* that you pay when you receive a covered service. For example, a member might pay for 30 percent of charges for covered durable medical equipment.

**Copayment (or copay).** The fixed amount you pay when you receive covered medical services or prescriptions. For example, a member might pay $30 for each office visit, $500 for each day in the hospital, and $20 for each drug prescription filled at our pharmacies. Copayments vary depending on your plan.

**Cost-sharing.** This refers to any benefit plan in which you pay for part of the cost of your care. This can be through copayments, coinsurance, or deductibles.

**Deductible.** A fixed amount of money you must pay in a calendar year for certain services before we will cover those services. Not all services may be subject to a deductible.

**Liability.** Your share of cost for the services provided to you or your family under this plan.

**Patient name.** Name of the person who received care.

**Plan benefit.** The difference between the allowed amount and your liability.

**Reference number.** A number used to identify services you received.

**Service date.** Date member received care from the provider.

**Service description.** Health care service received.

## Explanation codes

| | | |
|---|---|---|
| ADAMT | = | Incorrect allowed/billed amount |
| ADCOB | = | Coordination of benefits adjustment |
| ADCOI | = | Co-insurance adjustment |
| ADCOP | = | Copayment adjustment |
| ADDED | = | Deductible adjustment |
| ADDUP | = | Duplicate claim/service |
| ADREC | = | Reconsidered previously denied claim |
| ADTER | = | Retroactive member termination |
| ADTPL | = | Recovery, third-party liability/ workers' compensation |
| ADVOI | = | Void claim |
| ADWM | = | Processed under the wrong member ID |
| ADWPC | = | Processed with wrong procedure code |
| ADWPR | = | Processed under the wrong provider |
| C | = | Services billed by Kaiser Permanente and other providers |
| K | = | Services billed by Kaiser Permanente |
| P | = | Services billed by providers other than Kaiser Permanente |
| Rx | = | Bill from Kaiser Permanente pharmacy |
| T | = | Bill from ambulance service |

## Have questions about this statement?

Call us at **1-800-390-3507**, Monday through Friday, from 8 a.m. to 8 p.m., or write to us at:

Kaiser Permanente
Deductible Products Service Team
P.O. Box 1059
Corona, CA 92878

## Have questions about your benefits?

Call our Member Service Call Center, seven days a week, 7 a.m. to 7 p.m., at **1-800-464-4000** or **1-800-777-1370** (TTY for the hearing- or speech-impaired).

This statement shows the accumulation of your deductible and out-of-pocket maximum for the calendar year. Any services received or billed after the statement date will not appear on this statement. The statement also assumes that you've paid your share of any costs.

Member and Marketing Communications
0130-0020-01-r02