Your **deductible plan.**

Sharing the cost for your care.

Kaiser Foundation Health Plan, Inc.
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Member and Marketing Communications
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KAISER PERMANENTE®

Understanding Your Deductible Plan

You are enrolled in one of Kaiser Permanente's deductible plans. Whether you're a longtime member switching from our traditional plan or just joining Kaiser Permanente for the first time, it's important to understand how a deductible plan works so you can get the most out of your care.

The main difference between a deductible plan and our traditional plan is the amount you pay for care when you go to the doctor or hospital. You'll pay more for care—if you need it—because you pay lower monthly premiums up front.

While how much you pay at the time of service is different, you still receive the same high-quality care you've come to expect from Kaiser Permanente.

What's a deductible?

You may know about deductibles from other insurance plans you've purchased, like home or auto insurance policies. Our deductible plans work in much the same way. Your plan has a set amount known as the deductible. At the start of each calendar year, you pay out of your own pocket for care you receive until you reach your deductible.

Once you meet your deductible, we pay for most covered services (not including applicable copayments or coinsurance) for the rest of the calendar year. On January 1 of the next year, you start over and pay full charges for your care until you reach your deductible.

There are several types of deductible plans, and each works in a slightly different way. Deductibles also work differently for individual and family plans. The following are some common features of deductible plans to help you better understand how they work. To learn more about your specific plan and benefits, consult your *Evidence of Coverage* or call our Member Service Call Center at the phone numbers listed at the end of this brochure.

Key features of a deductible plan

- **Payment at the time of service:** For services that apply to your deductible, you pay full charges for the care you receive until you meet your deductible. Other services may require only a copay or coinsurance. When you arrive at your appointment, you'll be expected to make this payment before you receive care.
- **Applying payments to the deductible:** With a deductible plan, there's a running total of how much you spend until you reach your deductible. But not all services apply to the deductible. Some services, such as certain preventive care, require only a copayment, which is not added to your running total.
- **Billing for additional services:** ***What you pay at the time of service may be only a deposit.*** There may be remaining charges, or you may need additional services that were not scheduled. You'll receive a bill for those services later.
- **Meeting the deductible:** Once you meet your deductible, you'll pay only a copayment or coinsurance for most covered care and services for the rest of the calendar year.
- **Prescription drug deductible:** Some plans have both a medical deductible and a separate pharmacy deductible. Check your *Evidence of Coverage* or call our Member Service Call Center to see if this applies to you.
- **Reaching the out-of-pocket maximum:** Along with your deductible, you have a limit known as the out-of-pocket maximum. This amount is higher than your deductible and acts as a cap for most covered services on your annual out-of-pocket payments—including copayments and coinsurance. Having a set limit for the calendar year can give you peace of mind if you have major medical expenses.

Three Steps to Using Your Plan

Whenever you need care, keep the following three steps in mind so you'll know what to expect from your deductible plan.

1 Before your visit

Because you're expected to pay for most charges up front until you meet your deductible, it may help to know ahead of time how much you'll be expected to pay when you arrive. Here are some ways to find out:

- **Online:** Go to **kp.org/treatmentestimates** to view the *Kaiser Permanente Sample Fee List*. This list includes fees for certain services such as office visits, medications, lab tests, and X-rays.
- ***Evidence of Coverage:*** This booklet explains your plan benefits. You should have received it with your enrollment materials. For a free copy, ask your employer's human resources representative or call our Member Service Call Center at **1-800-464-4000** or **1-800-777-1370** (TTY), weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.
- **By phone:** Call our Deductible Products Service Team at **1-800-390-3507,** Monday through Friday, from 7 a.m. to 5 p.m., and we'll be happy to assist you in getting an estimate of charges before your appointment.

2 At your visit

Every time you come in for care, from regular office visits to hospitalization, you'll be asked to pay for the services you're about to receive. How much you pay will depend on whether the services you receive apply to the deductible or if you've already met your deductible. If you haven't met your deductible, you'll be expected to pay the full charges. If you have met your deductible, or if the services are preventive care that don't apply to the deductible, you'll pay either a copayment or coinsurance, depending on your plan. Remember that what you pay at the time of service may be only a deposit. Until you reach your deductible, you may be billed for any additional services you received during your visit that were not originally scheduled. For example, you may pay the full charges for an office visit, but during your visit your doctor orders lab tests that weren't originally scheduled. You'll receive a bill for the lab charges later.

For your convenience, most of our facilities accept major credit cards.

3 After your visit

There are two types of statements you'll receive from us in the mail.

- **Statement of Accumulation (SOA):** *This is not a bill.* The SOA is sent every 30 days and lists all the services you've received. It will also include a running total of the expenses that apply to your deductible and out-of-pocket maximum. (Under our accounting system, services you receive and any related payments may take 30 to 45 days to appear on your SOA.) You can also go to **kp.org/treatmentestimates** to view a sample SOA.
- **Bill for services:** If you received additional services during a visit that weren't scheduled, then you'll be billed for those charges later. You'll receive a bill between one and four weeks after the visit. The bill will include charges for any care received that you may not have paid for at the time of your visit (for example, lab tests or X-rays). You can also go to **kp.org/treatmentestimates** to view a sample bill.

Because of the time it takes for items to show up in your account, your SOA and bill may not always reflect the most recent charges. The charges may appear in the next statement.

Statement of Accumulation (SOA)


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

Bill for services


KAISER PERMANENTE
SCAL PHYSICIAN BILL FOR SERVICE DEDUCTIBLE PLAN
Guarantor Account Number: 999999999
AMOUNT YOU OWE $10.00
DO NOT SEND CASH
SEND PAYMENT TO:

How a deductible plan works for an individual

The following is a brief example of how a deductible plan works. The amounts shown here are for illustration purposes only and may not be the amount you would pay for the same services.

Seeing a doctor. Kimberly has a benefit plan with an annual deductible of $1,500 and an annual out-of-pocket maximum of $3,000. She gets sick and makes an appointment to see her personal physician. She goes online to **kp.org/treatmentestimates** to check the sample fee list and finds out that an office visit will be $75. At her doctor's office, she pays $75 during registration. When she sees her physician, he orders additional lab tests and X-rays, which cost a total of $125. She receives a bill a few weeks after her visit for $125 to cover the additional services. Kimberly has spent a total of $200 for her care so far this year. She has to spend another $1,300 to reach her deductible.

Reaching the deductible. Kimberly is admitted to the hospital. With the amount she pays for her care, she reaches her $1,500 deductible for the year. Now when she needs care, she'll pay just a copayment or coinsurance. Most of what she spends for covered services will continue to apply to her out-of-pocket maximum of $3,000.

Starting a new year. After meeting her deductible, Kimberly continues paying for her care through any applicable copays or coinsurance for the remainder of the year. On January 1, the running total for her deductible returns to zero. Again, she pays full charges for care she receives in the new calendar year until she reaches her $1,500 deductible.

How a deductible plan works for a family

For most family plans with a deductible, each family member has a deductible, and the family as a whole has a deductible. If an individual reaches his or her deductible before the family meets its deductible, we'll pay for covered services for that family member (not including copays or coinsurance) for the remainder of the calendar year. The other family members will continue to pay for their care until they satisfy their individual deductibles or until the family meets its family deductible.

For certain HSA (health savings account) deductible plans for families, there is only one deductible for the entire family. In this case, it doesn't matter when each individual family member reaches the deductible. Once it's met—whether by one family member or the total of all the family members—then we'll pay for covered services for the entire family for the remainder of the calendar year.

Common Terms

Here are some terms you may come across when reading about your deductible plan. Some of these terms are also defined in your *Evidence of Coverage*.

Coinsurance. The percentage of charges you pay when receiving a covered service. For example, you might pay 30 percent of the charges for covered durable medical equipment.

Copayment (or copay). The fixed amount you pay when you receive covered medical services or prescriptions. For example, you might pay $10 for each office visit, $100 for each day in the hospital, and $20 for each prescription filled at our pharmacies. Copayments vary depending on your plan.

Cost sharing. This refers to any benefit plan feature where a member pays for part of the cost of his or her care. Members can share costs through copayments, coinsurance, or deductibles. The amount a member pays for services is in addition to the member's regular monthly health plan premiums.

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

Annual out-of-pocket maximum. The maximum amount you'll pay for eligible covered services in a calendar year. For example, under some benefit plans, the total of a member's applicable deductible, applicable coinsurance, and applicable copayment is limited to an annual out-of-pocket maximum of $3,000. Once you've reached that maximum you won't have to pay any copayments, deductibles, or coinsurance for most covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum.

Whom to Call

For more information about your benefits, please refer to your *Evidence of Coverage*. If you have questions, visit our Member Services Department at the facility nearest you or call our Member Service Call Center, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.

1-800-464-4000 English
1-800-788-0616 Spanish
1-800-757-7585 Chinese dialects
1-800-777-1370 TTY (for the hearing/speech impaired)

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