

PAYING FOR CARE

We're here to help you better understand the financial aspects of your deductible plan. Understanding your costs can help you feel more comfortable in deciding how to spend your health care dollars.

While a deductible plan works a little differently than a traditional HMO plan, you still get the high quality of care you've come to expect from Kaiser Permanente. The steps in this brochure will help guide you through the basics of what to expect and where to go for financial information before, during, and after a visit.



A FOCUS ON PREVENTION

One important way to stay healthy is by detecting problems before they become serious. That's why your deductible plan offers most preventive care services—like routine physical exams, mammograms, and cholesterol screenings—at little or no out-of-pocket cost to you, even before you've met your deductible. Visit kp.org/deductibleplans to see a list of preventive care services or to use our online Estimates tool to see how much upcoming services might cost.

Learn more about how your deductible plan works at kp.org/deductibleplans.

1

Before your visit—getting an estimate.

Before coming in for an appointment, it helps to have an estimate of how much your visit will cost, depending on the care you expect to receive.

For a personalized cost estimate:*

- **Try our online Estimates tool:** Use this convenient resource to get an estimate of what you'll pay out of your own pocket for many of the most common exams, tests, and procedures. The Estimates tool knows your plan benefits and whether or not you've met your annual deductible—so estimates are based on your personal situation. You can find the tool at kp.org/memberestimates.
- **Call us:** While you can get cost estimates for most common services on our website, estimates for certain services may not be available. If you can't get an estimate for a particular service online, call **1-800-390-3507**, weekdays from 7 a.m. to 5 p.m.

The screenshot displays the Kaiser Permanente website's 'Estimate details' page. The main heading is 'Knee Replacement estimate for Sample Patient'. Below this, it shows the 'Estimate number' as 00000 and the 'Request date' as 09-01-2016. A table titled 'Your estimated cost' compares 'Typical services' and 'Most complex services'. The table shows that for typical services, the patient's plan allows \$0 and the patient pays \$0, while for most complex services, the plan allows \$1000 and the patient pays \$1000. A 'Total Fee' section indicates a deductible of \$0 for both service types. A disclaimer at the bottom states: 'These amounts are based on your deductible and out-of-pocket maximum at the time this estimate was created. See the out-of-pocket summary below for more information.' A checkbox at the bottom indicates the user has agreed to the 'Conditions of Use'.

	Typical services	Most complex services
Your plan allows	\$0	\$1000
Your plan pays	\$0	\$1000
Your estimated cost	\$0	\$1000
Total Fee		
Deductible	\$0	\$1000

*Estimates are based partly on services that have been processed by our billing system.

COMMON TERMS

Annual out-of-pocket maximum: The maximum amount you'll pay for certain covered services in a calendar year. Once you've reached that maximum, you won't have to pay any deductibles, copays, or coinsurance for most covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum. For HSA-qualified plans, all services, except for certain preventive services, are subject to the deductible, and all services apply toward the out-of-pocket maximum.

Coinsurance: The percentage of charges you pay when receiving certain covered services. For example, 30 percent coinsurance for hospitalization means you pay 30 percent of the charges for covered hospital services. Coinsurance, which varies depending on your plan, doesn't apply toward your deductible. But it does count toward your annual out-of-pocket maximum.

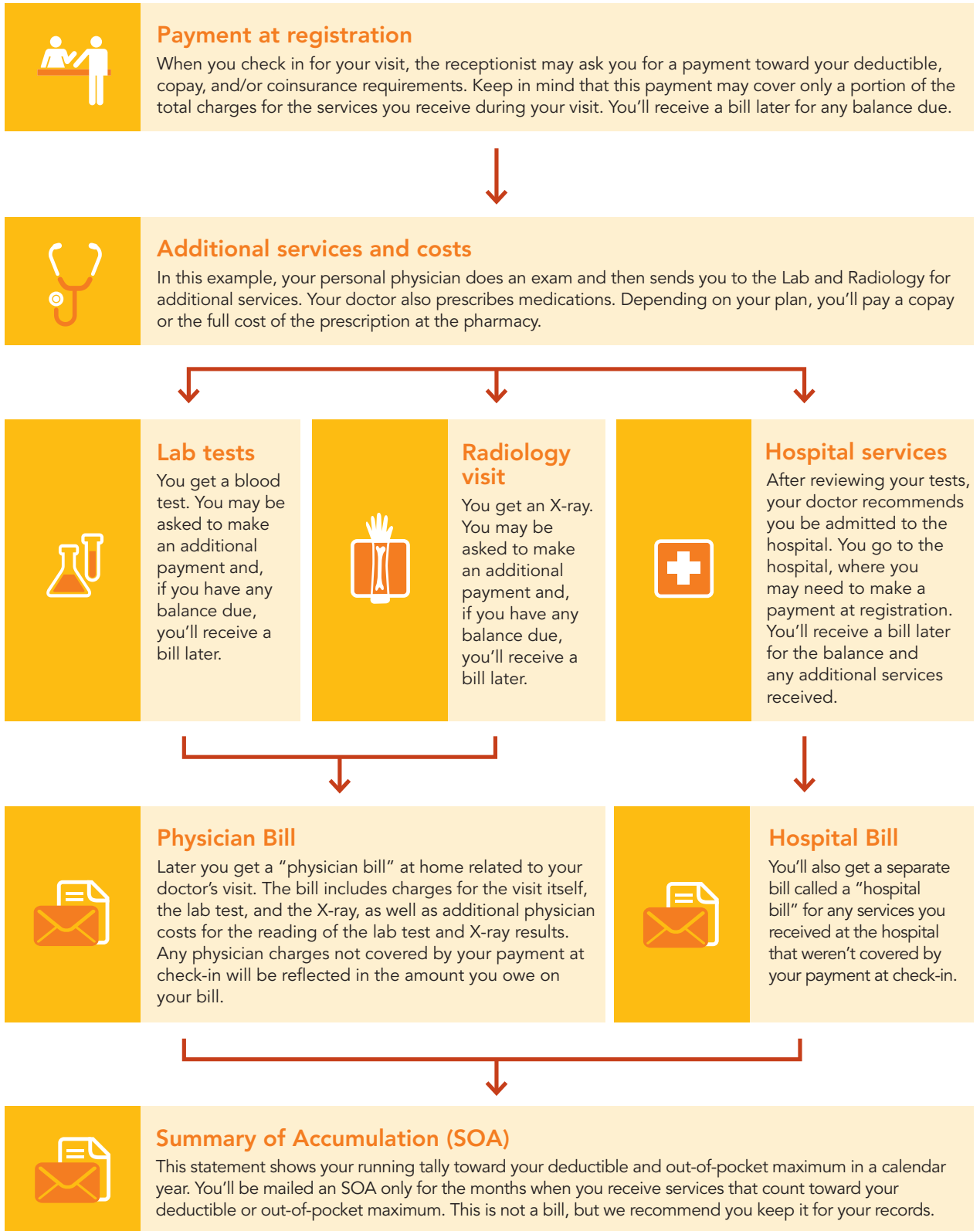
Copayment (or copay): The fixed fee you pay when you receive certain covered services or prescriptions. For example, a \$10 office visit copay means you pay \$10 for each office visit. Copayments, which vary depending on your plan, don't apply toward your deductible. But they do count toward your annual out-of-pocket maximum.

Deductible: A set amount you pay in a calendar year before we provide most covered services at a copay or coinsurance. Not all services may count toward the deductible. For HSA-qualified plans, all services, except for certain preventive services, are subject to the deductible, and all services apply toward the out-of-pocket maximum.

2

During your visit—what to expect.

This chart shows how the services you receive affect how much and when you pay for care.




3

After your visit—receiving your bill.

You should get a bill after your visit if:

- Your payment at check-in didn't cover the full cost of the services you received during your visit.
- You received additional services during your visit.

Reading your bill



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PHYSICIAN BILL FOR SERVICE DEDUCTIBLE PLAN

Statement Date: 08/31/2010
 Guarantor Medical Record Number: 000099999999

Guarantor Account Number: 123456789

JANE DOE
 71234 MAIN ST
 ANYWHERE, CA 99999-4444

Due Date: 09/20/2010 **Amount You Owe: \$63.00**

Date	Patient's Name	Provider	Service Description	Charges	Payments/ Adjustments	Balance
07/31/10	JANE DOE	JONES MD, C.	OFFICE VISIT LOW MOD	\$202.00		\$0.00
07/31/10	JANE DOE		PATIENT PAYMENT (AT CHECK-IN)		-\$20.00	
08/20/10			INSURANCE ADJUSTMENT		-\$142.00	
08/20/10			INSURANCE PAYMENT		-\$40.00	
07/31/10	JANE DOE	JONES MD, C.	BLOOD CREATININE LAB TEST	\$64.00		\$10.00
07/31/10	JANE DOE	JONES MD, C.	LIPID PANEL LAB TEST	\$122.00		\$33.00
07/31/10	JANE DOE	JONES MD, C.	COMPLETE BLOOD COUNT (CBC)	\$60.00		\$20.00
08/20/10			INSURANCE ADJUSTMENT		-\$183.00	
08/20/10			INSURANCE PAYMENT		\$0.00	
Totals				\$448.00	-\$385.00	
AMOUNT YOU OWE:				→		\$63.00
Minimum Amount Due:						\$63.00

- A Charges:** The amounts in this column represent the total charge for each service you received. Think of them as the price we would charge individuals who are not Kaiser Permanente members.
- B Insurance Adjustment:** This is an amount deducted from the "charges" due to contractual agreements with your insurance provider, or other adjustments your insurance makes.
- C Insurance Payment:** This is how much your insurance paid toward the services you received. This amount is determined by your specific insurance coverage and plan benefits.

MORE ABOUT YOUR BILL


Your current bill may not always reflect your most recent charges or payments. Services and related payments may take up to 125 days to appear on your bill, but occasionally some may take longer. These services and payments will appear on a future bill.

Sometimes, you may see a payment but not the related charges for a service. That could be because your payment was recorded before the charges for a service were processed. If so, the charges will appear on a future bill.

Also, remember that you may receive more than one bill for a single service—a "physician bill" and a "hospital bill." If you don't see all the charges for a service on one bill, they will appear on a future bill.

Understanding your bill

Now that you know the key elements of a bill, let's go over some sample charges.



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Guarantor Account Number: 123456789

Due Date: 09/20/2010 **Amount You Owe: \$63.00**

Date	Patient's Name	Provider	Service Description	Charges	Payments/Adjustments	Balance	
D	07/31/10	JANE DOE	JONES MD, C.	OFFICE VISIT LOW MOD	\$202.00		\$0.00
	07/31/10	JANE DOE		PATIENT PAYMENT (AT CHECK-IN)		-\$20.00	
	08/20/10			INSURANCE ADJUSTMENT		-\$142.00	
	08/20/10			INSURANCE PAYMENT		-\$40.00	
E	07/31/10	JANE DOE	JONES MD, C.	BLOOD CREATININE LAB TEST	\$64.00		\$10.00
	07/31/10	JANE DOE	JONES MD, C.	LIPID PANEL LAB TEST	\$122.00		\$33.00
	07/31/10	JANE DOE	JONES MD, C.	COMPLETE BLOOD COUNT (CBC)	\$60.00		\$20.00
	08/20/10			INSURANCE ADJUSTMENT		-\$183.00	
	08/20/10			INSURANCE PAYMENT		\$0.00	
Totals				\$448.00	-\$385.00		
				AMOUNT YOU OWE: →		\$63.00	
				Minimum Amount Due:		\$63.00	

D Office visit charges: In the example above, Jane Doe visited Dr. Jones on July 31, 2010. The visit resulted in charges of \$202. Since she's a Kaiser Permanente member, the amount was reduced by \$142. That's known as the "Insurance Adjustment." So the expected member charge for her doctor's visit is \$60 (\$202 - \$142 = \$60).

But Jane's deductible plan covers office visits at a \$20 copay. That's why the "Insurance Payment" is \$40. This is how much her insurance pays under her deductible plan benefits. When Jane checked in, she paid the \$20 copay to the receptionist. The bill shows this as a "Patient Payment (at Check-in)" of \$20, which leaves a patient balance of \$0.

E Additional charges: That same day, Jane's doctor sent her for lab tests. The bill shows she received three different lab tests with total charges of \$246 (\$64 + \$122 + \$60 = \$246). This was adjusted by \$183 since she's a Kaiser Permanente member, bringing the total member charge to \$63. Because the receptionist didn't ask Jane to make a payment for these lab tests, the bill doesn't show any "Patient Payment" from Jane. And since Jane's deductible plan doesn't cover lab tests at a copay before she reaches her deductible, the bill shows an "Insurance Payment" of \$0. This means she's responsible for paying the full member charge for the lab tests, which is \$63.


F Amount you owe: Jane's total due for this bill is \$63 for the lab tests, since she already paid the copay for her doctor's visit when she checked in.

4


At home—keeping track of your deductible and out-of-pocket maximum.

Reading your Summary of Accumulation (SOA): This document lists all your medical costs that have been applied toward your deductible and out-of-pocket maximum during the calendar year. You'll be mailed an SOA only for the months in which you receive services that count toward your deductible or out-of-pocket maximum. Keep in mind that services may take several months to show up on your SOA. **This is not a bill.**

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P.O. BOX 830913
BIRMINGHAM, AL 35283-0913



ADDRESSEE:

----- manifest line -----



JANE DOE
71234 MAIN ST
ANYWHERE, CA 99999-4444

Summary of Accumulation (SOA): This is sent following any activity on your account and lists all the services applied toward your medical deductible and out-of-pocket maximum. FSA/HRA/HSA members should keep this Summary of Accumulation and other health care receipts for tax purposes.

Date: 08/31/2010
Subscriber Number: 110011110011
Group ID: 000000001
Benefit Package ID: D286364

Questions?
 Contact: Deductible Products Service Team
 Hours of Operation: Mon.-Fri., 7 a.m.-5 p.m.
 Phone: 1-800-390-3507

Thank you for selecting Kaiser Foundation Health Plan, Inc. for your health care needs.

PLEASE RETAIN FOR YOUR RECORDS

**Summary of Amounts Applied Toward Your Individual and Family Deductible and OOP Max
01/01/10–12/31/10**

Individual Deductible = \$1,500.00	Individual OOP Max = \$3,500.00
Family Deductible = \$3,000.00	Family OOP Max = \$7,000.00

B

	Applied This Period		Applied Year to Date	
	Deductible	OOP Max	Deductible	OOP Max
Individual Accumulation Totals				
JANE DOE	63.00	83.00	150.00	200.00
JOHN DOE			100.00	150.00

A

	Applied This Period		Applied Year to Date	
	Deductible	OOP Max	Deductible	OOP Max
Family Accumulation Totals				
Accumulation Totals	63.00	83.00	250.00	350.00

- A Amounts applied so far:** These are the total charges applied to your deductible and out-of-pocket maximum for the year. If you reach your deductible and out-of-pocket maximum, you won't receive SOAs for the rest of the year.
- B Tracking individual amounts:** These are the deductible and out-of-pocket maximum totals for you and each family member in your household. When a family member reaches his or her individual deductible, that family member will pay only a copay or coinsurance for most covered services.*
- C Tracking family amounts:** These are the total charges applied to your calendar-year family deductible. After this deductible is met, every family member will pay only copays or coinsurance for most covered services.

*Some of our HSA-qualified deductible plans only feature family deductibles. That means that once the family collectively satisfies the deductible, then the family only pays a copay or coinsurance for most covered services.

THIS IS NOT A BILL

The information below only includes amounts that have been applied toward your deductible or out-of-pocket maximum since your last summary.

Service Description	Date of Service	Patient's Name	Claim No.	Allowed Amount <small>(Charge/Invoice Adjustment)</small>	Insurance Adjustment	Patient Responsibility			Applied Toward OOP Max	Explanation Code*
						Applied Toward Deductible	Copay	Coinsurance		
OFFICE VISIT LOW MOD	07/31/10	JANE DOE	I4392340DE566	\$60.00	(\$40.00)		\$20.00		\$20.00	
Laboratory Tests	07/31/10	JANE DOE	I234DFF4060	\$63.00		\$63.00			\$63.00	
Total Applied Toward Deductible:						\$63.00				
Total Applied Toward Out-of-Pocket Maximum:									\$83.00	

D Our responsibility: The amounts under "Allowed Amount" show the Kaiser Permanente member charges for services. The amounts under "Insurance Adjustment" show what Kaiser Permanente is responsible for paying. "Insurance Adjustment" amounts depend on which deductible HMO plan you have.

E Your responsibility: The amounts listed under "Patient Responsibility" show what you're responsible for paying. This is the difference between the "Allowed Amount" and the "Insurance Adjustment." What you pay can fall into three categories: "Applied Toward Deductible," "Copay," or "Coinsurance."

Keep in mind that copays and coinsurance aren't applied to your deductible.

But the amounts listed in the deductible, copay, and coinsurance columns do apply toward your out-of-pocket maximum for the calendar year.

To find out if you've met your deductible or out-of-pocket maximum, or if you have questions about your bill or Summary of Accumulation (SOA):

Call **1-800-390-3507**, weekdays from 7 a.m. to 5 p.m. To get a quick look at your deductible or out-of-pocket maximum accumulations online, use our Out-of-Pocket Summary tool at kp.org/outofpocket.

QUESTIONS AND ANSWERS

ABOUT YOUR DEDUCTIBLE HMO PLAN

Why do I seem to pay a different copay each time I check in for a visit?

The amount you pay at check-in isn't always just a copay, and will vary depending on how much of your deductible or out-of-pocket maximum you've satisfied, as well as on the actual cost of the service. After you've met your deductible, you'll pay a simple copay or coinsurance amount, depending on your plan coverage.

Why are the cost estimates given to me before my visit different from what I'm finally billed?

The cost estimates you get from our online Estimates tool or our telephone representatives are based not only on the cost of procedures and services you expect to receive, but also on your plan details and how close you are to meeting your deductible and out-of-pocket maximum at the time you receive the estimate. Since not everything about your visit can be known in advance, you may end up owing more or less than your original estimate. You'll receive a bill if your payment at check-in didn't cover the full cost of the services you received, or if you received additional services.

If I have a health reimbursement arrangement (HRA) or health savings account (HSA), can I use it to pay for care?

Yes. You can use these funds to pay for qualified medical expenses,* either when registering for a visit or when you get a bill. If you'd like to pay a bill with your HRA or HSA, complete the credit card portion of the bill with your HRA or HSA card information. Then mail it back to us to complete the payment process. For more information on HRAs and HSAs, go to kp.org/deductibleplans.

Do the bills or SOAs provide information on my HRA or HSA balance? Where can I get that information?

No, neither the bills nor the SOAs provide information on your HRA or HSA balance. To get this information, please contact your HRA or HSA administrator.

*To view the list of qualified medical expenses as defined under Internal Revenue Code Section 213(d), download IRS Publication 502, *Medical and Dental Expenses*, at www.irs.gov/publications. As an HSA holder, you'll ultimately be responsible for determining whether an expense is a qualified medical expense under the tax laws. For HRA accounts, the HRA administrator is responsible for that determination. The Internal Revenue Service requires that all HRA and HSA transactions be validated, so it's important that you save all your receipts in case your HRA administrator or the tax authorities require additional information.

kp.org/deductibleplans