

2013

Change the way you look at health

DEDUCTIBLE HMO PLAN FOR THE CITY OF ALEXANDRIA

GLOSSARY

Allowable charge (or allowed amount) The amount the provider may charge for a certain service, based on an agreement between the provider and the insurer.

Annual out-of-pocket maximum The maximum amount you pay out-of-pocket each contract year for most covered services. Once the amounts you have paid equal the out-of-pocket maximum, you pay nothing for those covered services for the remainder of the contract year. There are some covered services that do not count toward meeting the out-of-pocket maximum. You will have to continue to pay your copayments or coinsurance for those covered services.

Billed amount The total amount that a provider charges for rendered services, which may be greater than the allowed amount.

Coinsurance The percentage of the allowed amount that you are responsible for paying when you receive certain covered health care services. Coinsurance varies according to your plan and does not apply toward the deductible. However, it counts toward your annual out-of-pocket maximum for most services.

Copayment (or copay) The set dollar amount you pay each time you receive certain covered health care services. Copayments vary depending on your plan and do not count toward the deductible. However, they do count toward your annual out-of-pocket maximum for most services.

Contract year The 12-month period of time your plan contract is in effect before it has to be renewed. Your contract year may begin and end in any consecutive 12-month period, depending on your group's or your individual agreement with the health plan. (Some individual plan members may have a 12½-month contract year the first year of membership, depending on their effective date.)

Deductible The set amount you must pay each contract year for certain covered services before you can receive the services at a copay or coinsurance. Not all services may be applied to the deductible. Deductibles vary, depending on the plan you have, so read your *Evidence of Coverage* to learn about your plan.

WHAT IS A DEDUCTIBLE HMO PLAN?*

A way to get the health care that fits your lifestyle and your budget.

A deductible HMO plan is much like a traditional HMO plan, but with an important difference: With a deductible HMO plan, for some covered health care services, you must first pay a predetermined amount each contract year (the annual deductible), before the health plan begins to pay for covered services.

You might already be familiar with one type of deductible—most auto insurance policies have deductibles. For example, you might have an auto policy that requires you to pay the first \$500 of charges to repair your car after an accident. Health care deductible plans are similar, but you are only required to meet the deductible once each contract year.

Another difference between a deductible HMO plan and a traditional HMO plan is the amount you pay in monthly premiums. With a deductible plan, you will typically pay a lower monthly premium. This can give you more flexibility in deciding how to spend your health care dollars.

HOW YOUR KAISER PERMANENTE DEDUCTIBLE HEALTH PLAN WORKS

Your plan has a contract year medical deductible that applies to all covered health care services, except preventive services and prescription drugs. Each time you receive these health care services, you will be responsible for paying the allowable charge (or allowed amount) until you have reached your contract year deductible. (The allowable charge may be less than the billed amount charged by the provider. You are only responsible for paying the allowed amount.)

It's important to obtain an authorized referral before you visit a non-plan provider. Without an authorized referral, the amount you pay the non-plan provider will not count toward your annual deductible or out-of-pocket maximum.

Once the total of the allowed amounts you have paid is equal to your contract year deductible amount, the health plan will begin to pay its share of the charges. For the rest of the contract year, you will pay only the applicable copayment or coinsurance for covered services you receive.

* The information in this brochure does not apply to Maryland Small Group deductible HMO plans.

Some services are not subject to the deductible. This means that you do not have to meet the deductible and the health plan pays its share right away for these services. Examples of services that are not subject to the deductible include preventive services and prescription drugs.

Your *Evidence of Coverage* describes in detail which services are subject to the deductible and which are not.

In most cases, you will not have to pay anything for preventive health services such as routine physicals, well-child visits, and certain screening tests. Preventive health services are not subject to the deductible, so there is no reason to postpone getting the important preventive health check-ups and screenings that you need. There is a more detailed description of preventive health services on page 13 of this brochure.*

Even after you have met your deductible, your medical expenses could continue to add up. Your deductible health plan offers you the peace of mind of knowing that there is a limit on the amount that you are required to pay for most covered services each contract year. This amount is called the out-of-pocket maximum.

The deductible amount you pay, as well as copayments and coinsurance for most services, count toward meeting the out-of-pocket maximum limit. Once you reach the out-of-pocket maximum limit, you will not have to pay for any covered services that count toward the out-of-pocket maximum for the rest of the contract year. Charges for some services do not count toward meeting the out-of-pocket maximum. You should refer to your plan's *Evidence of Coverage* for more information.

*Please see your *Evidence of Coverage* for the list of covered preventive health services.



YOUR EXPENSES: KNOW WHAT TO EXPECT

Your deductible plan works a little differently than a traditional HMO plan. Part of using your deductible plan is knowing ahead of time how much and when to pay for services.

Before your visit

To help you plan in advance for your costs as well as your care, you can get an estimate before you come in for care, based on the care you expect to receive.

- **Online:** You will find estimated charges for commonly used medical services and prescription medications on kp.org/treatmentestimates.
- **By phone:** You can call Member Services for answers to your questions about your covered plan services and for cost estimates. Sometimes we may contact you before a scheduled visit at a Kaiser Permanente medical center to provide you with a personalized cost estimate.

During your visit

If you receive preventive health services, you won't pay anything whether you did or did not meet your deductible.

If the services you receive are not subject to the deductible, you are responsible for only the applicable copayment or coinsurance.

If you have not yet met your deductible, you will be responsible for full payment for any covered services that are applied to the deductible. You will be responsible for the allowed amount and your payment will count toward meeting your deductible.

If you already have met your deductible, you will pay either a copayment or coinsurance. And, if you have already met your out-of-pocket maximum, you will pay nothing for most covered services for the remainder of the contract year.* Sometimes you may be asked to make a deposit payment at the time of check-in.

* Please refer to your Evidence of Coverage to find out which services are subject to out-of-pocket maximum.

After your visit

You will be sent a bill in the mail for the amount you owe (if any) for the medical services you received. If you made a deposit payment before or at your medical appointment, and if there is a difference between your payment and the actual cost, you will be sent a bill or a refund in the mail.

If you received services outside of a Kaiser Permanente medical center and paid the full service fees, be sure to send a copy of your receipt, along with a claim form, or ask the service provider to bill us. Submit claim forms and receipt to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attn: Claims Department

P.O. Box 6233, Rockville, MD 20849-6233.

Doing so ensures that the proper amounts are applied to your deductible balance and/or out-of-pocket maximum balance.

You may receive any of the following documents following your visit:

Explanation of Benefits (EOB): The EOB shows you a running tally of expenses applied toward your deductible and out-of-pocket maximum. The EOB is not a bill; it is a summary of the payment(s) for services that have been applied to your deductible and out-of-pocket maximum.

Statement of Accounts (your bill for services): If you owe more than the amount you paid during your visit, you will be billed for the balance. Your bill might also include the charges for any additional services you received during your visit. If you have a balance on your account, you will receive a bill every month until the balance is paid.

Please note: If your EOB and bill do not reflect the most recent charges that apply to your deductible, the more recent charges might appear on your next statement or bill.



AN EXAMPLE OF PAYING FOR YOUR CARE WITH A DEDUCTIBLE HMO PLAN



BEFORE YOUR VISIT

Get an estimate of your costs based on the care you expect to receive. Go online to kp.org/treatmentestimates or call Member Services.



CHECKING IN AT REGISTRATION

When you come in for your visit, the receptionist may ask you to make a copayment or a deposit payment.



DOCTOR'S VISIT

Your physician examines you and then sends you to the lab and radiology for additional services. Your doctor also prescribes medications, and you make a payment at the pharmacy.

LAB TESTS



You get a blood test. You will be billed later.

RADIOLOGY VISIT



You get an X-ray. You may be asked to make a copayment or a deposit payment and receive a bill or refund later, or you may just be billed later.

HOSPITAL STAY



After reviewing your tests, your doctor admits you to the hospital. You go to the hospital and you may be asked to make a deposit payment at registration. You will be billed the difference later.



PHYSICIAN BILL

About a month after your visit, you will get a physician bill related to your doctor's visit. The bill includes additional physician charges for the reading of the lab test and X-ray results.



HOSPITAL BILL

About the same time you receive your physician bill, you will also receive a separate bill from the hospital for the services you received there. You will be billed for the balance that you owe.



EXPLANATION OF BENEFITS

Soon after your appointment, tests, and hospital stay, you will receive an explanation of the services you have received. It will show you a running tally of expenses applied toward your deductible and out-of-pocket maximum. Your EOB is not your bill.

If you receive services outside of a Kaiser Permanente medical center and pay the full-service fees, be sure to send a copy of your receipt, along with a claim form, or ask the service provider to bill us. This will ensure that the proper amounts are applied to your deductible balance or out-of-pocket maximum balance. Submit claim forms and receipts to: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attn: Claims Department, P.O. Box 6233, Rockville, MD 20849-6233.

SAMPLE SITUATIONS

Individual and family plan deductibles and out-of-pocket maximums

If you have coverage for yourself only, you have one individual deductible for the contract year. If you have coverage for yourself and one or more family members, each covered person has a deductible and the whole family has a separate deductible that must be met. All appropriate charges for each family member's care are applied to the family deductible.

When one family member reaches his or her individual deductible limit before the family deductible is met, that family member pays only applicable copayments and coinsurance amounts for covered services for the rest of the contract year. The other family members continue to pay the allowable charges until either each remaining family member has met his or her individual deductible, or the family deductible is met. Once the family deductible is met, you begin paying only the applicable coinsurance amounts for everyone who is covered, whether or not each family member's individual deductible has been met. The out-of-pocket maximum works the same way.





Example 1: Susan is single and has no dependents.

Susan is enrolled in a deductible HMO plan with the following benefits:

- \$15 copay for primary care physician visits
- \$25 copay for specialist visits
- No charge for preventive health services
- \$150 copay for emergency room services
- \$500 copay for inpatient services
- \$50 copay for outpatient surgery
- \$0 copay for diagnostic laboratory and radiology services
- \$400 individual deductible
- \$2,200 individual out-of-pocket maximum for the contract year

First visit of the contract year: Susan doesn't feel well and makes an appointment to see her primary care physician.

- Because Susan has not yet reached her contract year deductible, she pays the allowable charge of \$70 for the primary physician office visit.
- The amount counts toward meeting the deductible and is applied against her out-of-pocket maximum.
- Susan's primary care physician refers her to a specialist for further care.

Second visit: Susan visits a specialist.

- Because Susan has not yet reached her contract year deductible, she pays the allowable charge of \$130 for the specialist office visit. The amount counts toward meeting the deductible and is applied against her out-of-pocket maximum.
- The physician orders lab tests and an X-ray. The lab and X-ray services are also subject to the deductible.
- Because Susan has not yet reached her contract year deductible, she pays the allowable charge of \$50 for the lab tests and \$150 for the X-ray. The \$200 lab and X-ray charges are applied to her out-of-pocket maximum.

Third visit: Susan is admitted to the hospital for a two-day stay.

- The total hospital charge is \$2,500. Susan has met her \$400 deductible amount for the contract year. She pays the \$500 copay for inpatient hospital services.

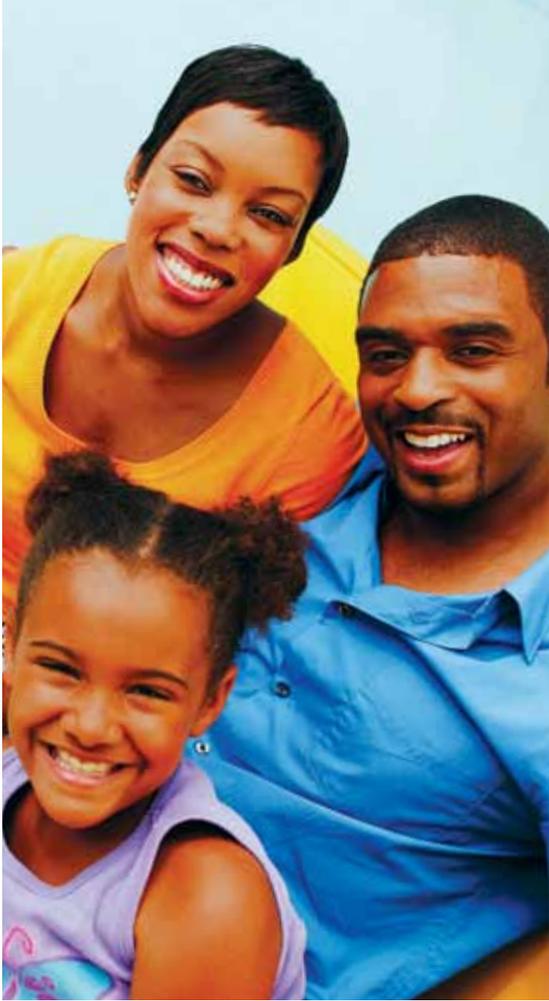
Fourth visit: Susan sees the specialist for a follow-up visit and is sent for an X-ray.

- Susan pays a specialist office visit copayment of \$25 and, because she has met her contract year deductible, she has a \$0 copay for the X-ray.
- The \$25 copayment is applied toward her annual out-of-pocket maximum.

SUSAN'S MEDICAL CARE HISTORY

VISIT	Services provided	Total allowable charge	Susan pays	Accrued to \$400 deductible	Remaining deductible to be met	Accrued to out-of-pocket maximum of \$2,200
1	Primary care visit	\$70	\$70 allowable charge	\$70	\$330	\$70
2	Specialty care office visit	\$130	\$130 allowable charge	\$130	\$200	\$130
	X-ray	\$150	\$150 allowable charge	\$150	\$50	\$150
	Lab tests	\$50	\$50 allowable charge	\$50	\$0	\$50
3	2-day inpatient hospital stay	\$2,500	\$500 copay for inpatient services	\$0	\$0	\$500
4	Specialty care office visit	\$130	\$25 copay	\$0	\$0	\$25
	X-ray	\$150	\$0	\$0	\$0	\$0
TOTAL				\$400 (deductible met)	\$0	\$925 (\$1,275 remaining)

Susan has now met her annual deductible, so she pays only the applicable copayment or coinsurance for the covered services she receives for the rest of the contract year. The copayments and coinsurance amounts she pays will continue to apply toward her annual out-of-pocket maximum. If Susan should reach the annual out-of-pocket maximum limit of \$2,200 for her plan, she will not have to pay any additional charges for the remainder of the contract year for the covered services that are subject to the out-of-pocket maximum.



Example 2: Robert is married and has one child. His spouse and child are covered under his health plan.

Robert is enrolled in a deductible HMO plan with the following features:

- \$15 copay for primary care physician visits
- \$25 copay for specialist visits
- No charge for preventive health service
- \$150 copay for emergency room services
- \$500 copay for inpatient services
- \$50 copay for outpatient surgery
- \$0 for diagnostic laboratory and radiology services
- \$75 copay for outpatient specialty imaging
- \$400 individual/\$800 family deductible
- \$2,200 individual/\$6,400 family out-of-pocket maximum

First visit of the contract year: Robert has an appointment for a routine physical with his primary care physician.

- A routine physical is considered a preventive health service. However, Robert was diagnosed with a health problem, and the visit became non-preventive and subject to the office visit allowable charge of \$70. The \$70 counts toward meeting his individual and family deductibles and is applied to his individual and family out-of-pocket maximums.
- Robert's primary care physician refers him to a specialist for further care.

Second visit: Robert visits the specialist.

- Because Robert has not yet reached his contract year deductible, he pays the allowable charge of \$130 for the specialist office visit. The payment counts toward meeting the individual and family deductibles and is applied toward his individual and family out-of-pocket maximum.
- The physician orders a magnetic resonance imaging test (MRI).
- The allowable charge for the MRI is \$1,500. Because Robert has not yet reached his contract year deductible, he must first meet his

individual deductible amount of \$400. The difference after his deductible is met is \$1,300. Robert's plan has a copay of \$75 for specialty imaging and diagnostic tests, so he owes \$75 for the test, plus the \$200 of the remaining individual deductible for a total of \$275. The \$275 is applied to his individual and family out-of-pocket maximum.

Third visit: Robert sees the specialist for a follow-up visit and receives a prescription.

- Robert pays a specialist office visit copayment of \$25 and a \$15 copayment for a generic drug at the Kaiser Permanente pharmacy.
- The \$25 office visit copayment is applied toward his individual and family out-of-pocket maximum, but not the \$15 prescription copayment.

Fourth visit: Robert's child gets sick and receives urgent care. His child then receives follow-up treatment through a specialist, including the laboratory and specialty imaging tests.

- Because Robert's child has not met her deductible, Robert pays the allowable charge of \$150 for his child's urgent care and a \$150 copayment for specialty care. These amounts count toward meeting the child's and family deductibles and apply to the individual and family out-of-pocket maximums.
- Robert's child meets her individual deductible of \$400 after paying the allowable charge of \$100 for the laboratory tests.
- When the child's individual expenses are combined with what Robert spent earlier in the year, the family deductible of \$800 is also met.
- Robert pays \$75 copay for specialty imaging tests that applies to his child's individual and their family out-of-pocket maximums.
- The copayments and deductible payments, totaling \$475, are applied toward the annual individual and family out-of-pocket maximums.

Fifth visit: Robert's spouse has outpatient surgery.

- Because the family deductible has been met, Robert pays the copay of \$50 for his spouse's outpatient surgery. This amount counts toward his spouse's individual and their family out-of-pocket maximums.
- Robert's spouse does not need to meet her individual deductible because the family deductible already has been met.
- Because the family deductible has been met, everyone, including Robert's spouse who has not received any prior services, will pay either copayments or coinsurance for covered services for the remainder of the contract year.

ROBERT'S FAMILY MEDICAL CARE HISTORY

VISIT	SERVICES PROVIDED	TOTAL ALLOWABLE CHARGE	ROBERT PAYS	ACCRUED TO DEDUCTIBLE		ACCRUED TO OUT-OF-POCKET MAXIMUM	
				Individual \$400	Family \$800	Individual \$2,200	Family \$6,400
1 (Robert)	Routine physical exam	\$70	\$70 allowable charge	\$70	\$70	\$70	\$70
2 (Robert)	Specialty care office visit	\$130	\$130 allowable charge	\$130	\$130	\$130	\$130
	MRI test	\$1,500	\$200 deductible plus \$75 copay. Total of \$275.	\$200	\$200	\$275	\$275
3 (Robert)	Specialty care office visit	\$150	\$25 copayment	\$0	\$0	\$25	\$25
	Generic prescription drug	N/A	\$15 copayment	\$0	\$0	\$0	\$0
TOTAL (ROBERT)				\$400 (indiv. #1 deductible met)	\$400	\$500 ((\$1,700 remaining for indiv. #1)	\$500 ((\$5,900 remaining for family)
4 (Child)	Urgent care	\$150	\$150 allowable charge	\$150	\$150	\$150	\$150
	Specialty care office visit	\$150	\$150 allowable charge	\$150	\$150	\$150	\$150
	Lab tests	\$100	\$100 allowable charge	\$100	\$100	\$100	\$100
	Specialty imaging	\$850	\$75 copay	\$0	\$0	\$75	\$75
TOTAL (CHILD)				\$400 (indiv. #2 deductible met)	\$800 (family deductible met)	\$475 ((\$1,725 remaining for indiv. #2)	\$975 ((\$5,425 remaining for family)
5 (Spouse)	Outpatient surgery	\$500	\$50 copay	N/A	\$0	\$50	\$50
TOTAL (SPOUSE)				\$400 + \$400	\$800 (family deductible met)	\$50 ((\$2,150 remaining for indiv. #3)	\$1,025 ((\$5,375 remaining for family)

PREVENTIVE HEALTH SERVICES

We know that preventive health services are the key to keeping you healthy. With our deductible HMO plans, preventive health services are available to you without first having to meet your contract year deductible.

All Kaiser Permanente deductible benefit plans cover a preventive health services package that includes the more than 80 preventive health services recommended by the U.S. Preventive Services Task Force, applicable state preventive health services mandates, plus an annual routine physical exam. You pay no copayments or coinsurance for these preventive health services when performed by a plan provider.

Covered preventive health services include, but are not limited to, the following age- and gender-appropriate exams, screening tests, and the corresponding explanation of the results:

- Well-woman exams, including pap smears and screening mammograms
- Well-child examinations
- Routine, age-based immunizations
- Osteoporosis screening for women
- Colorectal cancer screenings
- Cholesterol screening tests

During a preventive health service visit, if it becomes necessary to perform a diagnostic or therapeutic service (e.g., if a diagnosis is made and a non-preventive procedure is performed) you may be required to pay a cost share for the diagnostic or therapeutic services.

You may also be responsible for deductibles, copayments, and coinsurance for other services not included in the preventive health services package described above. Examinations, tests, X-rays, and other services required for managing health problems (seeing the doctor for joint pain, insomnia, or the flu, for example) and chronic conditions are not considered preventive health services.

QUESTIONS AND ANSWERS ABOUT YOUR DEDUCTIBLE HMO PLAN

Why am I asked for a different copayment each time I come for a service?

If you have not met your deductible, you may be asked for a different amount at registration based on the services provided. It could be a copayment, coinsurance, or a payment toward your deductible, depending on the services you receive. Once you have met your deductible, the amount due will typically be a standard copayment or coinsurance amount. A copayment is a fixed amount you pay for certain services, while a coinsurance payment is a certain percentage (defined by your plan design) of the allowable charge for the service, and a deductible payment is the full member charge for the service.

Why can't I pay the actual cost of services during my appointment?

We might not know what services you will receive until your doctor examines you. After your appointment, your doctor will record all the care and services you received during your visit. This will determine what your total charges will be. These charges, minus the amount you paid before or during your appointment, will appear on the bill you receive later. If you made a deposit payment when you checked in, you will receive a bill or refund for the difference between your payment and the actual cost.

Why are the estimates I read online or that are given to me by Member Service representatives before my visit different from what I am actually charged?

The amounts you read online or that are given to you by our Member Services representatives are *estimated* costs for typical health care services. We may contact you before a scheduled health service to provide you with a personalized cost estimate. When you receive a service, the *actual* cost will depend on the level of care you receive and the place of the service. Also, the estimate is based on typical charges and does not take into account your specific plan benefits.

WHOM TO CALL

For information about your bill or estimate of charges, to ask about your benefits, or to receive a copy of your *Evidence of Coverage*, call Member Services at 1-800-777-7902 (toll free), Monday through Friday, 7:30 a.m. to 5:30 p.m. TTY/TDD users should call 301-879-6380.

GO ONLINE

Visit kp.org.



NOTES





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