

CHANGE THE WAY YOU LOOK AT HEALTH



2015 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

A different kind of plan. A different way to pay for your care.

BETTER INFORMED. BETTER TOGETHER

Your Kaiser Permanente HSA-qualified deductible plan is not just health coverage—it's a partnership in health. With your Georgia deductible plan, you get a Kaiser Permanente care team that works closely with you to help you stay healthy. You also have flexibility in managing your health care spending, which can give you greater control over your costs. You receive most preventive care services at little or no cost to you, and online access to manage your care around the clock.

Your benefits include:

- a primary care physician for routine medical care
- copayments or coinsurance for most covered services after you meet your deductible
- no referrals needed for specialties at Kaiser Permanente medical facilities
- an out-of-pocket maximum that limits how much you'll spend on most services each year
- no additional coinsurance needed after the annual out-of-pocket maximum is met
- a pre-tax health savings account to help pay for certain medical expenses[†]

A GOOD HEALTH CARE PLAN HAS ITS ADVANTAGES

A Kaiser Permanente HSA-Qualified Deductible HMO Plan lets you manage your personal health *and* your financial health. Because this type of deductible HMO plan meets U.S. Treasury guidelines, you can pair it with a health savings account (HSA). An HSA allows you to use pre-tax dollars to pay for your qualified medical expenses, including payments toward your deductible.* It can also be paired with a health reimbursement account (HRA), if chosen by your employer.

[†] To be eligible for an HSA, you must be enrolled in an HSA-qualified deductible health plan and meet other HSA eligibility rules. For more information, refer to IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, available online at [irs.gov/publications](https://www.irs.gov/publications) or by calling 1-800-829-3676. To view the list of qualified medical expenses defined under Internal Revenue Code Section 213(d), see IRS Publication 502, *Medical and Dental Expenses*. The tax references in this document relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws.

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

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 most covered health care services, you must first pay a predetermined amount—the annual deductible—each calendar or contract (if applicable) year before the health plan begins to pay its share for covered services and you can begin paying just copayments or coinsurance.

You may already be familiar with one type of deductible insurance—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 pay the deductible once every calendar or contract (if applicable) year.

Deductible plans from Kaiser Permanente work a lot like our traditional plans, with all the same resources to help you get healthy and stay that way. The main difference is how you pay for care.

With your new deductible plan, you can set up a tax-free health savings account (HSA) that you can access anytime to help pay for qualified medical expenses.

You'll pay full charges for most services—including prescription drugs—until you reach your deductible. Then you'll pay just a copay or coinsurance for most services covered by your plan for the rest of the calendar year.

Even before you reach your deductible, most preventive care services will be covered at little or no cost to you.

Your new plan also features an annual out-of-pocket maximum, which gives you peace of mind by limiting the total amount you'll pay for most covered services each calendar year.

It's easy to get a cost estimate for common medical services before you come in for care. Our treatment fee tool and Sample Fee List will give you an idea of how much you'll need to pay for scheduled services.

HOW YOUR KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HEALTH PLAN WORKS

Your plan has a calendar or contract (if applicable) year medical deductible that applies to all covered health care services—including prescription drugs—and excluding preventive health services. 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 deductible. (The allowable charge may be less than the billed amount charged by the provider. You are only responsible for paying the allowable charge.¹)

It's important to obtain an authorized referral before you visit providers outside Kaiser Permanente facilities. Without an authorized referral, the amount you pay such providers will not count toward your annual deductible or out-of-pocket maximum.

Once the total of the allowable charges you have paid is equal to your deductible amount, the health plan will begin to pay its share of the charges. For the rest of the calendar or plan (if applicable) year, you will pay only the applicable copayment or coinsurance for covered services you receive.² On the first day of your plan year or calendar year, as applicable, you'll start over and pay the allowable charges for all services—except preventive health services—until you reach your deductible again.

Preventive health services, such as routine physicals, well-child visits, and certain screening tests, are not subject to the deductible and are usually available without a copay or coinsurance. This means that whether you did or did not meet the deductible, the health plan pays 100 percent for these services received from contracted providers.

There is a more detailed description of preventive health services on page 15 of this brochure.³

¹ If you are enrolled in a plan with more than one coverage tier, and non-contracted (out-of-network) providers are seen for routine and follow-up care, the provider may bill you for the difference between billed and allowable amounts.

² Once you reach your out-of-pocket maximum, the health plan will pay 100 percent of allowable charges.

³ Please see your Evidence of Coverage for the list of covered preventive health services.

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 in knowing that there is a limit on the amount that you are required to pay for covered services each calendar or contract (if applicable) year. This amount is called the out-of-pocket maximum.

The deductible amount you pay, as well as copayments and coinsurance, count toward meeting the out-of-pocket maximum limit. If you should reach the out-of-pocket maximum limit, you will not have to pay for any covered services for the rest of the calendar or contract (if applicable) year.

The benefit information provided in this brochure is a brief summary, but it is not a comprehensive description of available benefits. For the most up-to-date and accurate information about your plan's benefits, cost shares, and exclusions and limitations, refer to your *Evidence of Coverage*.

YOUR EXPENSES: KNOW WHAT TO EXPECT

Your deductible plan works a little differently than a traditional HMO plan.

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 by using our sample fee list and treatment fee tool at kp.org/treatmentestimates.
- **By phone:** You can call Member Services at the number listed in the back of this brochure 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 facility 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 you have not yet met your deductible, you will be responsible for payment for any covered services—*except preventive health services received from contracted providers*. You will be responsible for the allowable charge, and your payment will count toward meeting your deductible and out-of-pocket maximum. If you have met your deductible, you will be responsible for any applicable copayment or coinsurance for covered services. Sometimes you may be asked to make a deposit payment when you check in for your appointment.

If you have already met your out-of-pocket maximum, you will pay nothing for covered services for the remainder of the calendar or contract (if applicable) year.

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 allowable charge, you will be sent a bill or a refund in the mail. See pages 6-7 for an example bill and information to help you understand it.

If you received services outside of a Kaiser Permanente medical facility 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 receipts to:

Kaiser Foundation Health Plan of Georgia, Inc.

Attn: Claims Department

P.O. Box 190849, Atlanta, GA 31119-0849

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

Following your visit, you may receive an *Explanation of Benefits* (EOB). An EOB is sent following any activity on your account and lists all the services you have received. It will show 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 services that have been applied to your deductible and out-of-pocket maximum.

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

AN EXAMPLE OF PAYING FOR YOUR CARE WITH AN HSA-QUALIFIED 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 for 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, and may be asked to make a deposit payment and receive a bill or refund later, or you may 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

(Statement of Account)

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

(Statement of Account)

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 (EOB)

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 facility 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 Georgia, Inc., Attn: Claims Department, P.O. Box 190849, Atlanta, GA 31119-0849.

AFTER YOUR VISIT—RECEIVING YOUR BILL (STATEMENT OF ACCOUNT)

You'll 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



**KAISER
PERMANENTE®**

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PHYSICIAN BILL ACTIVITY

Guarantor Account #: 123456789101
 Bill Date: 08/14/2011
 Amount You Owe: \$150.00
 Due Date: 09/14/2011

JANE DOE
 71234 MAIN ST
 ANYWHERE, CA 99999-4444

BILLING DETAIL
Itemized charges and associated payment activity

Service Date	Post Date	Location	Provider	Description	Charges	Paid by Insurance/ Adjustments	Paid by You	Amount You Owe
DOE, JANE								
03/31/11	03/31/11	ANYWHERE CLINIC	BROWN, J.	OFFICE VISIT: MEDICAL EXAM (LEVEL 2, ESTABLISHED PATIENT) PATIENT PAYMENT (AT CHECK-IN)	\$200.00	-\$130.00		\$50.00
03/31/11		ANYWHERE CLINIC	GREEN, M.	LAB: ELECTROLYTE BLOOD MEASUREMENT	\$65.00	-\$35.00		\$30.00
03/31/11	04/03/11	ANYWHERE CLINIC	GREEN, M.	LAB: CREATININE BLOOD MEASUREMENT PATIENT PAYMENT (CHECK #111)	\$120.00	-\$70.00	-\$10.00	\$40.00
03/31/11		ANYWHERE CLINIC	GREEN, M.	LAB: THYROID MEASUREMENT	\$60.00	-\$30.00		\$30.00
TOTAL FOR DOE, JANE					\$445.00	-\$265.00	-\$30.00	\$150.00
TOTAL					\$445.00	-\$265.00	-\$30.00	\$150.00

- A Service and post date:** The service date is the date you came in for care or services. The post date is the date we processed any payments and adjustments related to those services.
- B Charges:** The total cost for services you received before we make any insurance payments or adjustments based on your benefits. Think of it as the price we would charge non-Kaiser permanente members.
- C Paid by insurance/adjustments:** this column lists any adjustments we've made to the charges, and any payments we made based on your health plan benefits.
- D Paid by you:** the amount you've already paid for care and services—for example, the amount you paid at check-in.

This is an example of what a bill may look like. Your actual bill may differ.

UNDERSTANDING YOUR BILL

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



JANE DOE
71234 MAIN ST
ANYWHERE, CA 99999-4444

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PHYSICIAN BILL ACTIVITY

Guarantor Account #: 123456789101
Bill Date: 08/14/2011
Amount You Owe: \$150.00
Due Date: 09/14/2011

BILLING DETAIL

Itemized charge and associated payment activity

Service Date	Post Date	Location	Provider	Description	Charges	Paid by Insurance/ Adjustments	Paid by You	Amount You Owe
DOE, JANE								
E	03/31/11	ANYWHERE CLINIC	BROWN, J.	OFFICE VISIT: MEDICAL EXAM (LEVEL 2, ESTABLISHED PATIENT) PATIENT PAYMENT (AT CHECK-IN)	\$200.00	-\$130.00	-\$20.00	\$50.00
	03/31/11	ANYWHERE CLINIC	GREEN, M.	LAB: ELECTROLYTE BLOOD MEASUREMENT	\$65.00	-\$35.00		\$30.00
F	03/31/11	ANYWHERE CLINIC	GREEN, M.	LAB: CREATININE BLOOD MEASUREMENT PATIENT PAYMENT (CHECK #111)	\$120.00	-\$70.00	-\$10.00	\$40.00
	04/03/11	ANYWHERE CLINIC	GREEN, M.	LAB: THYROID MEASUREMENT	\$60.00	-\$30.00		\$30.00
				TOTAL FOR DOE, JANE	\$445.00	-\$265.00	-\$30.00	\$150.00
				TOTAL	\$445.00	-\$265.00	-\$30.00	\$150.00

E Office visit charges: In the example above, Jane doe visited Dr. brown on March 31, 2011. The doctor's office visit cost \$200, but her Kaiser permanente plan paid \$130 of that amount. That makes her actual cost \$70 ($\$200 - \$130 = \70). Jane paid \$20 when she checked in, so she still owes \$50 ($\$70 - \$20 = \50) for her visit.

F Additional charges: That same day, Jane's doctor sent her to get three different lab tests with total charges of \$245 ($\$65 + \$120 + \60). Her Kaiser permanente plan paid \$135 ($\$35 + \$70 + \30), which means she's responsible for paying a total of \$110 for the three tests ($\$245 - \$135 = \$110$). Jane paid \$10 when she checked in at the lab, which means she still owes \$100.

G Amount you owe: This is the total amount Jane owes on her current physician's bill. It's determined by adding up the remaining costs of her office visit (\$50) and lab tests (\$100), which equal \$150.

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.

SAMPLE SITUATIONS

Individual and family deductibles and out-of-pocket maximums

If you have coverage for yourself only, you have one individual deductible for the calendar or contract (if applicable) year. If you have coverage for yourself and one or more family members, the whole family has a family deductible that must be met. All appropriate charges for each family member's care are applied to the family deductible. The family deductible can be met by one or more family members. Any combination of members' contribution toward meeting the family deductible is allowed. Once the family deductible is met, all covered family members begin paying only the applicable coinsurance or copayment amounts, whether or not each family member contributed to meeting the family deductible.

The out-of-pocket maximum works the same way. If you have coverage for yourself and one or more family members, the whole family has an out-of-pocket maximum that must be met. All appropriate charges for each family member's care are applied to the family out-of-pocket maximum. The family out-of-pocket maximum can be met by one or more family members. Any combination of members' contributions in meeting the family out-of-pocket maximum is allowed.

Once the family out-of-pocket maximum is met, you pay nothing for covered services for everyone who is covered for the remainder of the calendar or contract (if applicable) year, whether or not each family member contributed toward meeting the family out-of-pocket maximum.





Example 1: Susan is single and has no dependents.

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

- 20 percent coinsurance for primary care physician visits
- 20 percent coinsurance for specialist visits
- No charge for preventive health services
- \$100 copay for emergency room services
- 20 percent coinsurance for inpatient services, outpatient surgery, diagnostic laboratory, and radiology services
- \$1,500 individual deductible
- \$2,500 individual out-of-pocket maximum for the calendar year

First visit of the calendar year: Susan has an appointment for a routine physical with her personal physician.

- A routine physical is considered a preventive health service, so there is no charge.
- The visit is not subject to the deductible, and, because there is no charge, nothing is applied toward the out-of-pocket maximum.
- Susan's primary care physician refers her to a specialist for further care.

Second visit: Susan visits the specialist.

- Because Susan has not yet met her calendar year deductible, she pays the allowable charge of \$150 for the specialist office visit. The payment counts toward meeting the deductible and out-of-pocket maximum.
- The physician orders lab tests and an X-ray.
- Because Susan has not yet reached her deductible, she pays the allowable charge of \$200 for the lab tests and \$100 for the X-ray. The \$300 lab and X-ray charges are applied to her deductible and out-of-pocket maximum.

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

- The total hospital charge is \$3,000. Susan must first meet her remaining deductible amount of \$1,050. The difference after her deductible is met is \$1,950.
- Susan's plan has a 20 percent coinsurance for inpatient hospital services. In total, she owes the remaining deductible of \$1,050, plus 20 percent coinsurance (\$390) on the remaining balance of \$1,950, or \$1,440, which is applied to her out-of-pocket maximum.

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

- Susan has now met her calendar year deductible, so she pays 20 percent of the \$150 charge for the specialist visit and the \$120 charge for the X-ray. Her total charges are \$54.
- The \$54 coinsurance for both services applies toward her annual out-of-pocket maximum.

SUSAN'S MEDICAL CARE HISTORY

VISIT	Services provided	Total allowable charge	Susan pays	Accrued to \$1,500 deductible	Remaining deductible to be met	Accrued to out-of-pocket maximum of \$2,500
1	Routine physical exam	\$60	\$0 copay (no charge for preventive health services)	\$0	\$1,500	\$0
2	Specialty care office visit	\$150	\$150 full charge	\$150	\$1,350	\$150
	X-ray	\$100	\$100 full charge	\$100	\$1,250	\$100
	Lab tests	\$200	\$200 full charge	\$200	\$1,050	\$200
3	2-day inpatient hospital stay	\$3,000	\$1,050 remaining deductible, plus 20% coinsurance on \$1,950 balance, or \$390, for a total of \$1,440	\$1,050	\$0	\$1,440
4	Specialty care office visit	\$150	20% coinsurance of \$150 allowable charge, or \$30	\$0	\$0	\$30
	X-ray	\$120	20% coinsurance on \$120 allowable charge, or \$24	\$0	\$0	\$24
TOTAL				\$1,500 (deductible met)	\$0	\$1,944 (\$556 remaining)

Because Susan has now met her annual deductible, she pays only the applicable copayment or coinsurance for the care she receives for the rest of the calendar 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 \$2,500 for her plan, she would not have to pay any additional charges for the remainder of the calendar year for the covered services.



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:

- 20 percent coinsurance for primary care physician and specialist visits
- No charge for preventive health services
- 20 percent coinsurance for emergency room services, inpatient services, outpatient surgery, diagnostic laboratory, and radiology services
- \$1,200 individual/\$2,400 family deductible
- \$2,500 individual/\$5,000 family out-of-pocket maximum

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

- A routine physical is considered a preventive health service, so there is no charge, and the visit is not subject to the deductible.
- Robert's primary care physician refers him to a specialist for further care.

Second visit: Robert visits the specialist.

- Because Robert has not yet met the family's \$2,400 deductible, he pays the allowable charge of \$150 for the specialist office visit. The payment counts toward meeting the deductible, and is applied against the family out-of-pocket maximum.
- The physician orders an MRI test.
- The allowable charge for the MRI is \$1,500. Because the family deductible has not yet been met, Robert pays the full amount of \$1,500. The \$1,500 counts toward meeting the deductible and is applied against the family out-of-pocket maximum.

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

- Because the family deductible still has not been met, Robert pays the allowable charge of \$150 for the specialist office visit and a full charge of \$50 for a generic drug at the Kaiser Permanente pharmacy.

- Both payments count toward meeting the deductible and are applied against the family out-of-pocket maximum.

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

- Robert's family calendar year deductible has not yet been met, so Robert first pays \$550 to meet the remaining family deductible amount of \$2,400. The difference after the deductible is met is \$150. Robert's plan has a 20 percent coinsurance for diagnostic tests, so he owes \$30 for the test, plus the \$550 deductible for a total of \$580 for his child's emergency care. This service is subject to the deductible and is applied against the family out-of-pocket maximum.
- Now that Robert's family has met its deductible, all family members' charges will be 20 percent coinsurance of allowable charges for all covered services for the rest of the calendar year. Robert pays \$30 coinsurance for the specialist visit, \$40 coinsurance for the laboratory tests and \$200 coinsurance for specialty imaging tests.
- The coinsurance and deductible payments, totaling \$850, are applied toward the family annual out-of-pocket maximum.

Fifth visit: Robert is hospitalized for an urgent inpatient surgery.

- The total cost of the three-day stay, including the surgery, tests, procedures, and medications is \$7,000. Inpatient services are charged at 20 percent coinsurance of allowable charges as the family deductible has been met. Robert pays 20 percent coinsurance, or \$1,400, for the hospital services that apply to the family out-of-pocket maximum.

Sixth visit: Robert's spouse has outpatient surgery.

- The allowable charge for his spouse's outpatient surgery is \$1,500. He pays 20 percent of the allowable charge, or \$300. This amount counts toward the family out-of-pocket maximum.
- Robert's spouse does not need to meet the 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 20 percent coinsurance for covered services for the remainder of the calendar year.

ROBERT'S FAMILY MEDICAL CARE HISTORY

VISIT	SERVICES PROVIDED	TOTAL ALLOWABLE CHARGE	ROBERT PAYS	DEDUCTIBLE		OUT-OF-POCKET MAXIMUM	
				Accrued to \$2,400 family deductible	Remaining deductible to be met	Accrued to \$5,000 family out-of-pocket maximum	Remaining out-of-pocket maximum to be met
1 (Robert)	Routine physical exam	\$60	\$0	\$0	\$2,400	\$0	\$5,000
2 (Robert)	Specialty care office visit	\$150	\$150 full charge	\$150	\$2,250	\$150	\$4,850
	MRI test	\$1,500	\$1,500 full charge	\$1,500	\$750	\$1,500	\$3,350
3 (Robert)	Specialty care office visit	\$150	\$150 full charge	\$150	\$600	\$150	\$3,200
	Generic prescription drug	\$50	\$50 full charge	\$50	\$550	\$50	\$3,150
TOTAL				\$1,850	\$550	\$1,850	\$3,150
4 (Child)	Emergency care	\$700	\$550 remaining deductible, plus 20% coinsurance on \$150 balance, or \$30, for a total of \$580	\$550	\$0	\$580	\$2,570
	Specialty care office visit	\$150	20% coinsurance of AC,* or \$30	\$0	\$0	\$30	\$2,540
	Lab tests	\$200	20% coinsurance of AC,* or \$40	\$0	\$0	\$40	\$2,500
	Specialty imaging	\$1,000	20% coinsurance of AC,* or \$200	\$0	\$0	\$200	\$2,300
TOTAL				\$2,400 (Family deductible met)	\$2,400 (Family deductible met)	\$2,700	\$2,300
5 (Robert)	Inpatient surgery and 3-day stay in the hospital	\$7,000	20% coinsurance on \$7,000 allowable charge, or \$1,400	\$0	\$0	\$1,400	\$900
TOTAL				\$2,400 (Family deductible met)	\$2,400 (Family deductible met)	\$4,100	\$900
6 (Spouse)	Outpatient surgery	\$1,500	20% coinsurance on \$1,500 allowable charge, or \$300	\$0	\$0	\$300	\$600
TOTAL				\$2,400 (Family deductible met)	\$2,400 (Family deductible met)	\$4,400	\$600

Should the family reach the annual out-of-pocket maximum of \$5,000, none of the family members would have to pay any additional charges for covered services for the remainder of the calendar year.

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 calendar or contract (if applicable) 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 contracted 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
- Prescription birth control
- 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 nonpreventive 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.

PRESCRIPTION DRUG COVERAGE

With your HSA-qualified deductible health plan, the amount you pay for covered prescription drugs counts toward meeting your plan's annual deductible and out-of-pocket maximum. You will pay the full price for prescription drugs until your annual deductible is met, or until your family's annual deductible is met, if applicable. Once you have met your annual deductible, you are responsible only for applicable copayments or coinsurance for covered prescription drugs for the remainder of the calendar or contract (if applicable) year. The payments you make for covered prescription drugs also count toward your out-of-pocket maximum.

In most cases, your prescriptions will be covered under your HSA-qualified deductible HMO plan only if they are filled at a Kaiser Permanente (plan) pharmacy or a participating network pharmacy. You can use any Kaiser Permanente pharmacy or participating network pharmacy to fill your prescriptions. Keep in mind that your costs will usually be lowest when you use a Kaiser Permanente pharmacy. We will cover prescriptions filled at non-network pharmacies, under certain circumstances, as described in your *Evidence of Coverage*.

For a complete description of your prescription coverage, including how to fill your prescriptions, please review your *Evidence of Coverage* and the Kaiser Permanente formulary on [kp.org](https://www.kp.org). If you have additional questions, call Member Services at **404-261-2590** or **1-888-865-5813** (TTY **711**) Monday through Friday, 7 a.m. – 7 p.m., or visit [kp.org](https://www.kp.org).

Kaiser Permanente (plan) pharmacies

Kaiser Permanente pharmacies include the Kaiser Permanente mail order service and Kaiser Permanente medical facility pharmacies. Our pharmacies are conveniently located in most of the medical facility where you receive your care. You can also request mail delivery of most refills, at no additional cost, through our automated refill telephone line at **770-434-2008**, 24 hours a day, seven days a week, or visit **kp.org/rxrefill**.

Once you are registered at **kp.org**, you can request most refills online, receive refill reminders, read about your prescriptions, and see a list of your medication allergies. If you see a Permanente Medical Group provider who practices at one of our medical facilities, you can also email your doctor's office with non-urgent questions about your medicines, saving you a trip to the office.



QUESTIONS AND ANSWERS ABOUT YOUR DEDUCTIBLE HMO PLAN

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

We may 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 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 allowable amount.

Why are the estimates given to me before my visit different from what I am actually charged?

The online sample fee list and our Member Services representatives provide the 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 place of service, the level of care, and whether or not you have met your deductible and/or out-of-pocket maximum.

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

Yes. You can use these funds to pay for qualified medical expenses,* either when you register for a visit or when you get a bill. When you receive a bill and would like to pay 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.

Does the bill or *Explanation of Benefits* (EOB) provide information on my HRA or HSA balance?

No, neither the bill nor the *EOB* provides information about your HRA or HSA. You can get the information from your HRA or HSA administrator.

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

CALL US

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, Monday through Friday, 7 a.m. – 7 p.m. (EST):

- **404-261-2590** (local)
- **1-866-865-5813** (long distance)
- **711** (TTY)

GO ONLINE

For information about deductible plans, visit kp.org/deductibleplans, or if your employer has a Kaiser Permanente microsite, ask your human resources manager for the website address.

To learn more about Kaiser Permanente in Georgia, visit kp.org/georgia.



GLOSSARY

Allowable charge (or allowed amount) The amount that the health plan has agreed to pay to health plan providers (such as your doctor or a hospital) for covered services.

Annual out-of-pocket maximum The maximum amount you are required to pay out-of-pocket each calendar or contract (if applicable) year for covered services that are included in the out-of-pocket maximum. Once the amounts you have paid total the out-of-pocket maximum, you pay nothing for those covered services for the remainder of the calendar or contract (if applicable) year.

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

Calendar Year The period of time from January 1 of any year through December 31 of the same year. Even if your plan contract takes effect on a date other than January 1, calendar year accruals to deductibles and out-of-pocket maximums occur January 1 through December 31 of any given year.

Coinsurance The percentage of the allowable charge 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 does count toward your annual out-of-pocket maximum.

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.

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

Deductible The set amount you must pay each calendar or contract (if applicable) year for covered medical services that are subject to the deductible before the health plan begins to pay its share. 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.



Kaiser Foundation Health Plan of Georgia, Inc.

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kp.org/deductibleplans