

Understanding deductible plans



Understanding deductible plans

What is a copayment? What is a deductible? What charges apply toward your deductible? What is an annual out-of-pocket maximum? This section will explain these terms and help you understand how your plan works.

How deductible plans work

You're probably already familiar with deductible insurance—most home and auto insurance policies have deductibles. In a deductible plan, you pay for any costs up to a certain amount, which is called your deductible. Once you meet the deductible, we pay for any covered services (not including applicable copayments). Not all services you pay for apply toward your deductible.

Here are some real-life examples of how deductible plans work. The amounts shown here are for illustration purposes only and may not be the amount you would pay for the same service. What you pay at the point of service may be only an estimate of what you owe; there may be remaining charges, or you may need additional services that were not scheduled that you will be billed for later. Any additional payment is also applied to your deductible and out-of-pocket maximum, if applicable. If you have questions about your benefits, consult your *Evidence of Coverage* or call our Member Service Call Center. The phone numbers are listed in the “For more information” section on page 54.

How a deductible plan works for an individual

Meet Jan. Jan has a benefit plan with an annual \$1,500 deductible and an annual out-of-pocket maximum of \$3,000 per calendar year. The following are examples of services Jan received in a calendar year and what she paid for each visit.

First visit

- Jan doesn't feel well and goes to see her personal physician, who orders a lab test and an X-ray.
- She pays \$100 for the office visit, \$100 for the lab tests, and \$100 for the X-ray.
- Jan's total of \$300 is applied toward satisfying her \$1,500 deductible and to her annual out-of-pocket maximum.

Deductible subtotal: \$300

Out-of-pocket maximum subtotal: \$300

Second visit

- Jan has a vision test. She pays a \$30 copay.
- Jan's \$30 *does not* apply to her deductible because the test is a preventive care service, and with Jan's plan, certain preventive services are not subject to—and therefore do not count toward—her deductible. However, the copay is applied to her out-of-pocket maximum.

Deductible subtotal: remains at \$300

Out-of-pocket maximum subtotal: \$330

Third visit

- Jan needs to stay in the hospital for two nights. The hospital charge is \$1,200 per night.
- For the first night she pays \$1,200, which is added to her deductible. This brings her total deductible to \$1,500 and satisfies her deductible for the calendar year.
- Now that she's reached her deductible, Jan will pay only a \$500 copay for her second night's stay in the hospital.

Deductible total: \$1,500

Out-of-pocket maximum subtotal: \$2,030

Fourth visit

- Jan sees her personal physician for a follow-up visit, and her physician orders another X-ray and blood tests.
- Because Jan has reached her \$1,500 deductible, she will pay copayments for most covered services. For this visit, she pays copayments of \$30 for the office visit, \$10 for the X-ray, and \$10 for the blood test.
- The \$50 Jan paid in copayments is applied to her out-of-pocket maximum.

Deductible total: \$1,500

Out-of-pocket maximum subtotal: \$2,080

For the rest of the calendar year, Jan will continue to pay only copayments for covered services she receives, because she has reached her annual deductible. Most of her copayments will be added to her annual out-of-pocket maximum. Once she reaches her \$3,000 maximum, she will not pay any more copayments for most covered services that apply toward satisfying her out-of-pocket maximum.

There are some services, such as chemical dependency treatment, for which Jan would continue to pay copayments even though she has reached her out-of-pocket maximum. Please consult your *Evidence of Coverage* booklet for more information.

How a deductible plan works for a family

In a family deductible plan, 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). 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.

Confused? Not to worry. Hopefully this example will help clear things up.

Meet Cheryl and her husband, Jason, and their daughter, Tiffany. They are enrolled in a benefit plan as a family. They have a family deductible of \$3,000

per calendar year, and each family member also has an individual deductible of \$1,500. The family's out-of-pocket maximum is \$6,000.

Cheryl's visit

- Cheryl has already spent \$1,400 for previous services, which has been applied to her family's deductible of \$3,000, as well as to her individual deductible of \$1,500. Her husband and daughter together have spent \$800, which has also been applied to the family deductible.
- Cheryl goes to see her personal physician for the fifth time this calendar year. The total costs for services received during this visit is \$150. However, she only pays the remainder of her deductible, which is \$100, plus a \$30 copay for the office visit for a total of \$130. Because she's almost reached her deductible limit, Cheryl will pay either the fee for the service she receives or the remainder of her deductible plus any copayments, whichever is less. The \$130 Cheryl paid is added to her family's out-of-pocket maximum for the calendar year, \$100 of which is applied to the family's deductible. Because she has reached her individual deductible limit, Cheryl will generally pay a copay for covered services on subsequent visits for the rest of the calendar year. Other members of her family will continue to pay amounts toward the family's deductible.

Cheryl's deductible total: \$1,500

Family deductible subtotal: \$2,300

Family out-of-pocket maximum subtotal: \$2,330

Jason's visit

- Jason visits his personal physician who orders a procedure that costs \$1,000. So far this calendar year, Jason has spent \$200 for medical services that can be applied to his individual deductible of \$1,500. But because his family only needs to spend \$700 to reach the family deductible, Jason pays that amount for the service plus a \$50 copay instead of \$1,000.

Jason's deductible total: \$900

Family deductible total: \$3,000

Family out-of-pocket maximum subtotal: \$3,080

Even though Jason and Tiffany have not reached their individual deductible limits, they will only pay copayments for covered services they receive because the family has reached the family deductible limit of \$3,000. Their subsequent payments will continue to be added to the family's out-of-pocket maximum, if applicable. Once they reach their \$6,000 maximum, they will not pay any more copayments for most covered services that apply toward satisfying their out-of-pocket maximum.

There are some services, such as chemical dependency treatment, for which they would continue to pay copayments even though they have reached their out-of-pocket maximum. Please consult your *Evidence of Coverage* booklet for more information.

Frequently asked questions

Q: I paid a copayment for a preventive care service, but it wasn't applied toward my annual deductible. Why?

A: We encourage you to take advantage of our preventive care services, so we make services, such as vision exams, available to you at a copay before you reach your deductible. That's why we don't apply these fees to your deductible. In most cases, however, they are added to your annual out-of-pocket maximum. Please check your *Evidence of Coverage* or call our Member Service Call Center to find out which services apply toward your deductible.

Q: How will I know how much to pay for my visit?

A: Our receptionists can see in our computer system how much you owe for the service you receive. You will be asked to pay for any charges you owe at the time of your visit. Consult your *Evidence of Coverage* for more information. What you pay at the point of service is only an estimate of what you owe; there may be remaining charges, or you may need additional services that were not scheduled that you will be billed for later. Any additional payment is also applied to your deductible and out-of-pocket maximum, if applicable.

Q: My benefit plan has a medical services deductible. I went to the pharmacy, but the amount I paid for my prescription didn't apply toward my medical services deductible. Why?

A: In benefit plans with a medical services deductible, the amount you pay for drugs at the pharmacy doesn't apply toward satisfying your medical deductible. If it was a brand-name drug, the amount you paid may apply toward your pharmacy deductible, if applicable.

Q: My benefit plan has a pharmacy deductible. I went to the pharmacy, but the amount I paid for my prescription didn't apply toward my pharmacy deductible. Why?

A: Only outpatient brand-name drugs are subject to your pharmacy deductible. If you obtained a generic drug, it would not be subject to—and therefore not apply toward—your pharmacy deductible. Consult your *Evidence of Coverage* or ask your pharmacist for more details about which drugs are subject to the pharmacy deductible.

Q: When do I pay for services?

A: You should pay for services at the time you receive them, including copayments and deductibles. There will be a charge of \$13.50 to bill you if you are unable to make your payment at the time of service. We expect you to carry your Kaiser Permanente identification (ID) card and present it with another form of picture ID when you receive services.

For more information

For more information about benefits, please refer to your *Evidence of Coverage* booklet. If you have questions, you may visit our Member Services Department at the facility nearest you or you may call our Member Service Call Center, seven days a week, 7 a.m. to 7 p.m.

English	1-800-464-4000
Spanish	1-800-788-0616
Chinese dialects	1-800-757-7585
TTY	1-800-777-1370

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*.

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

Cost-sharing. This refers to any benefit plan in which a member pays for part of the cost of his or her care. This can be through copayments or deductibles. What 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 cover 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 copays 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 or deductibles for those covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum.