

How to read this statement



The Status of Deductible Plan Accumulation tells you how much you have accumulated toward your individual and family deductible and out-of-pocket (OOP) maximum. We'll send you a statement each time there is a change in the status of your accumulation. We're including the information below to help you understand how we calculate your deductible accumulation and your out-of-pocket maximum.

Common terms and codes

Here are some terms we use when talking about deductible products. Some of these terms are also defined in your Evidence of Coverage.

Allowed Amount. The maximum amount that a deductible plan member will pay for a given service.

Annual out-of-pocket maximum (OOP max). The maximum amount you'll pay for eligible covered services in a calendar year. For example, the total of a member's applicable deductible, most coinsurance, and most copays are limited to an annual out-of-pocket maximum of \$3,000 (individual) or \$6,000 (family). Once you have reached that maximum, you won't have to pay any copayments, deductibles, or coinsurance for those covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum.

Coinsurance. The percentage of charges, as defined by your *Evidence of Coverage*, that you pay when you receive a covered service. For example, a member might pay for 30 percent of charges for covered durable medical equipment.

Copayment (or copay). The fixed amount you pay when you receive covered medical services or prescriptions. For example, a member might pay \$30 for each office visit, \$500 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 you pay for part of the cost of your care. This can be through copayments, coinsurance, or deductibles.

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

Liability. Your share of cost for the services provided to you or your family under this plan.

Patient name. Name of the person who received care.

Plan benefit. The difference between the allowed amount and your liability.

Reference number. A number used to identify services you received.

Service date. Date member received care from the provider.

Service description. Health care service received.

Explanation codes

ADAMT	=	Incorrect allowed/billed amount
ADCOB	=	Coordination of benefits adjustment
ADCOI	=	Co-insurance adjustment
ADCOP	=	Copayment adjustment
ADDED	=	Deductible adjustment
ADDUP	=	Duplicate claim/service
ADREC	=	Reconsidered previously denied claim
ADTER	=	Retroactive member termination
ADTPL	=	Recovery, third-party liability/ workers' compensation
ADVOI	=	Void claim
ADWM	=	Processed under the wrong member ID
ADWPC	=	Processed with wrong procedure code
ADWPR	=	Processed under the wrong provider
C	=	Services billed by Kaiser Permanente and other providers
K	=	Services billed by Kaiser Permanente
P	=	Services billed by providers other than Kaiser Permanente
Rx	=	Bill from Kaiser Permanente pharmacy
T	=	Bill from ambulance service

Have questions about this statement?

Call us at **1-800-390-3507**, Monday through Friday, from 8 a.m. to 8 p.m., or write to us at:

Kaiser Permanente
Deductible Products Service Team
P.O. Box 1059
Corona, CA 92878

Have questions about your benefits?

Call our Member Service Call Center, seven days a week, 7 a.m. to 7 p.m., at **1-800-464-4000** or **1-800-777-1370** (TTY for the hearing- or speech-impaired).

This statement shows the accumulation of your deductible and out-of-pocket maximum for the calendar year. Any services received or billed after the statement date will not appear on this statement. The statement also assumes that you've paid your share of any costs.