

KAISER MEDICAL PLANS

GLOSSARY OF TERMS

Our glossary will help you learn more about health plan terms that appear on our Web site. Terms, definitions, and coverage levels may vary depending on service area.

Aggregate deductible or out-of-pocket maximum

An aggregate deductible, also referred to as an "umbrella" deductible, is a way to calculate deductibles or out-of-pocket maximums for family coverage. Once a member or any combination of that person's family members has met their plan's deductible, benefits begin for the entire family. Similarly, once a member or any combination of family members have met their plan's out-of-pocket maximum, no further member liability will apply for some or all covered services for the entire family. Not all services may be subject to the deductible and/or out-of-pocket maximum. (See [embedded deductible](#).)

Balance billing

Balance billing is a type of health care billing that occurs when a provider bills a member for the difference between an out-of-network provider's charges and the amount paid by a member's benefit plan. This situation happens when a provider is neither contracted nor a participant in a member's provider network.

CarePaySM

CarePay is Kaiser Permanente's suite of financial products that combine specific health plans with various types of financial accounts, such as CarePay Health Reimbursement Arrangement (HRA) accounts and CarePay Health Savings Accounts (HSA). When paired with a Kaiser Permanente health plan, these accounts offer a way to help our members manage and pay for out-of-pocket health care expenses.

Coinsurance

Coinsurance is a type of charge for covered health care expenses that a member must pay out of pocket according to his or her health plan. Coinsurance is charged as a predetermined percentage of the cost of covered services and is usually applicable after a deductible is met in a deductible plan, such as deductible HMO, preferred provider organization (PPO), point-of-service (POS), and indemnity plans.

Copayment

A copayment is the fixed dollar amount that a member must pay out of pocket for services covered by his or her health plan.

Covered health care expense

A covered health care expense is what a member must pay out of pocket for a product or service that is covered under his or her benefit plan. Covered health care expenses include deductibles, copayments, and coinsurance.

Members can refer to their Kaiser Permanente health plan documents for a comprehensive list of covered health care expenses (which vary depending on the benefit plan).

Deductible

A deductible is a predetermined amount that a member must pay out of pocket for services before his or her health plan begins to cover the charges of services. Not all services may be subject to a deductible. This type of cost-sharing mechanism is often found in deductible HMO, preferred provider organization (PPO), point-of-service (POS), and indemnity plans.

Deductible/coinsurance HMO plan

Kaiser Permanente's deductible/coinsurance HMO plans usually offer broad coverage with lower premiums than traditional HMO plans. They are similar to traditional HMO plans in that members access a closed network of physicians and other health care providers, and hospitals. A member typically pays a copayment for routine preventive care such as physicals and well-baby visits. In certain circumstances, preventive care is offered at no charge. For other services, such as hospitalization and outpatient surgery, a member and his or her family (if applicable) must meet the individual or family annual deductible. Once a member has met the deductible, he or she pays a portion of the charges for covered medical services (coinsurance or copayment). If a member has a lot of health care expenses in a year, a deductible/coinsurance plan can limit the amount paid out of pocket for most services.

Embedded deductible or out-of-pocket maximum

An embedded deductible is a way to calculate deductibles or out-of-pocket maximums for family coverage. Once a member has met his or her plan's individual deductible, benefits begin for that individual. Meanwhile, the rest of the family must continue satisfying their deductible until they reach the family-deductible level. Once the family deductible is satisfied, benefits begin for the rest of the family. Similarly, once a member has met his or her plan's individual out-of-pocket maximum, no further member liability will apply for some or all covered services for that individual. Meanwhile, the rest of the family must continue satisfying their out-of-pocket maximum until they reach the family out-of-pocket maximum level. Once the family out-of-pocket maximum is satisfied, then no further member liability will apply for some or all covered services for the rest of the family. Not all services may be subject to the deductible and/or out-of-pocket maximum. (See [aggregate deductible](#).)

Formulary

Formulary drugs are medications that have been thoroughly reviewed by a team of expert pharmacists and physicians and identified as safe, effective, and beneficial for treating medical conditions. When deciding between drugs that are equally safe and effective, the formulary team considers the relative costs of medications. These savings are then passed on to members through lower premiums or lower out-of-pocket expenses. (See [coinsurance](#) and [copayment](#).)

Health maintenance organization (HMO) plan

An HMO plan typically has a closed network of physicians and other health care providers, and hospitals. With a traditional HMO plan, a member receives services from the HMO's providers for a predetermined copayment. A member pays only copayments for services and doesn't have to worry about submitting claim forms unless he or she receives medical services outside the network. (See [deductible/coinsurance HMO plan](#).)

Health reimbursement arrangement (HRA)

HRAs are individual accounts that a member's employer can establish to help pay for covered medical expenses. The employer, who is the sole contributor to the HRA, decides how much money to put in the HRA and what percentage of unused HRA funds can roll over from year to year. A member can withdraw HRA funds for medical expenses allowed under an employer's benefits plan. HRA funds belong to the employer and are not portable, which means they do not go with a member if the member changes jobs. HRA funds are not treated as taxable income. (See the Internal Revenue Service's list of [qualified medical and dental expenses](#).)

Health savings account (HSA)

An HSA is a tax-advantaged savings account that a member can open to pay for qualified medical expenses. Contributions to an HSA can be made by both a member and his or her employer, but the money belongs to the member. The money invested in an HSA is tax-deductible, and any earnings are tax-deferred. The member can withdraw funds tax-free and without penalty from the account if the funds are used to pay for qualified medical expenses. The HSA is portable and goes with the member if the member changes jobs.

Tax references are applicable per federal tax regulations. State tax regulations may vary. (See the page about HSAs at the [U.S. Department of the Treasury](#) Web site.) (See the Internal Revenue Service's list of [qualified medical and dental expenses](#).)

Health Builder (HRA) (also referred to as "Kaiser Permanente Custom Care HealthBuilder (HRA)")

Our HealthBuilder (HRA) pairs a deductible/coinsurance HMO plan with a CarePay Health Reimbursement Arrangement account, which is funded by a member's employer. After a member enrolls in a CarePay HRA account, they will receive a CarePay HRA Visa[®] debit card that can be used to pay for covered health care expenses, including deductibles, coinsurance, and copayments.

HSA-qualified or HSA-compatible health plans (also referred to as "Kaiser Permanente Custom Care HealthInvestor (HSA)")

HSA-qualified health plans give a member flexibility and control over how and when to use health care dollars. Members get health care coverage while saving for future medical expenses through a health savings account (HSA), which offers some tax benefits.

With an HSA-qualified health plan, a member typically receives routine preventive care that is not subject to a deductible. These services include copayment or coinsurance, depending on the plan selected. In certain circumstances, preventive care is offered at no charge. For all other covered medical services and prescription drugs, the member and the member's family (if applicable) must meet the individual or family annual deductible. Once the member has met the deductible, he or she only pays a portion of the charges for covered medical services in the form of coinsurance or copayment. If the member has a lot of health care expenses in a year, an HSA-qualified health plan can limit the amount paid out of pocket for most services.

When a member enrolls in a Kaiser Permanente HSA-qualified health plan and chooses to open an HSA account with our preferred institution, the member will receive competitive pricing on fees with a range of investment options and dedicated customer service support.

In network

In network means a group of doctors, hospitals, pharmacies, and other providers that has contracted with a health plan to provide services to our members at negotiated rates. With all Kaiser Permanente health plans, members typically pay less out of pocket when seeking covered services from an in-network provider.

Letter of Medical Need

A Letter of Medical Need is a letter written by a doctor detailing a medical diagnosis and treatment.

The IRS requires that health care expenses reimbursed through a health reimbursement account be primarily for the diagnosis, treatment, or prevention of disease, or for treatments affecting any part of the body necessary for function. SHPS, the third-party provider Kaiser Permanente contracts with to administer Kaiser Permanente Custom Care HealthBuilder (HRA) accounts, may require members to submit additional documentation for verification; a Letter of Medical Need may be included in that documentation. For example, a doctor may prescribe a vitamin to treat a member for a medical condition. Because vitamins are generally considered a non-covered expense, the member may be asked to submit a Letter of Medical Need along with the reimbursement request.

Lifetime maximum

The lifetime maximum is the maximum amount of money a plan will pay towards a member's health care services.

Member liability

Member liability is the financial obligation a member has when obtaining health care services. Copayments, deductibles, and coinsurance are examples of member liabilities.

Out-of-area plan

if a member lives outside the area covered by his or her health plan, the member may still obtain a wide range of health benefits by purchasing an out-of-area plan. The member may receive care for covered services from any licensed provider who is not part of the health plan's network. The member must meet an annual deductible, pay coinsurance, and submit claims for reimbursement.

Out of network

Out of network means a group of doctors, hospitals, pharmacies, and other providers that has not contracted with a health plan to provide services to our members at negotiated rates.

Members typically pay more out of pocket when seeking services from an out-of-network provider. Depending on a member's plan benefits, the plan may or may not pay for a portion of the charges from out-of-network providers.

Out-of-pocket maximum

An out-of-pocket maximum is the limit to the total amount of deductibles, copayments, and coinsurance an individual or family must pay in a calendar, contract, or plan year for covered health care services.

At Kaiser Permanente, once the out-of-pocket maximum is reached, Kaiser Permanente pays for most or all of the covered services for the remainder of the calendar, contract, or plan year, depending on the plan. All covered services may not be subject to the out-of-pocket maximum.

Point of Service (POS) plans (also referred to as "Kaiser Permanente Flexible Choice, Added Choice, Multi-Choice")

A Kaiser Permanente Point of Service (POS) plan enables a member to receive care from either a Kaiser Permanente physician or any other physician or hospital, in or out of network, each time he or she needs health care services. Kaiser Permanente POS plans let our members decide how to manage their health care and costs to best meet their needs, each time they need care.

When enrolling in the Kaiser Permanente two-option or two-tier plan, a member has the choice of:

- receiving care from a Kaiser Permanente or affiliated physician, or
- receiving care from any licensed physician in the United States outside of the Kaiser Permanente network

When enrolling in the three-option or three-tier plan, a member has the choice of:

- receiving care from a Kaiser Permanente or affiliated physician
- receiving care from a doctor with our contracted preferred provider organization (PPO) network, or
- receiving care from any licensed physician in the United States outside of the Kaiser Permanente and our contracted PPO networks

Members can mix and match services among the network options—coverage and cost are determined by where a member chooses to get care. For example, members can take their kids to see a pediatrician outside our network and pay slightly higher rates. A POS health plan provides flexibility for different lifestyles and budgets.

Preferred provider organization (PPO) plan

In a Kaiser Permanente preferred provider organization (PPO) plan, members can choose from two coverage options each time they need medical care to get the health care that best meets their needs.

In Option 1 or Tier 1 (contracted network), a member may receive care from a provider in a contracted network. (Networks vary by region.) The member is responsible for meeting a deductible and paying coinsurance for services.

In Option 2 or Tier 2 (out of network), a member may receive care from any licensed provider or hospital that is not part of the health plan's network of contracted providers. When a member chooses this option, he or she will generally have higher out-of-pocket expenses than if they had used Tier 1. The member is also responsible for satisfying a deductible and/or paying coinsurance charges.

PPO plan with health savings account

A preferred provider organization (PPO) offers our members the freedom to choose who they want to see for health care. Combine a PPO plan with a health savings account (HSA) and our members get greater flexibility and control over how to use health care dollars while receiving tax advantages as they save for future health care expenses.

A PPO plan allows a member to choose his or her personal physician. The member pays lower out-of-pocket charges if he or she uses a physician from our nationwide preferred provider network, Private Healthcare Systems (PHCS), which has nearly 450,000 providers. The member's doctor may already be a part of the PHCS group. The member can still receive care outside of this network—all he or she needs to do is pay for the care and file a reimbursement claim.

Typically, in an HSA-qualified PPO, a member will not have to meet a deductible for preventive care such as physicals and well-baby visits. The member may also be able to access preventive care at no charge. For all other covered medical services and prescription drugs, the member and his or her family (if

applicable) must meet an individual or family annual deductible. Once the member has met the deductible, he or she pays a portion of the charge of covered medical services (coinsurance or copayment). If the member has a lot of health care costs in a year, he or she will have peace of mind knowing that there's a limit to out-of-pocket charges.

When a member enrolls in a Kaiser Permanente HSA-qualified PPO and chooses to open an HSA with our preferred institution, the member will receive competitive pricing on fees with a range of investment options and dedicated customer service support.

Qualified medical expenses

Qualified medical expenses are defined under Section 213 of the Internal Revenue Code. (See the Internal Revenue Service's *Publication 502* about [medical and dental expenses](#).) Qualified medical expenses and other expenses permitted to be reimbursed from health savings accounts (HSAs) include, but are not limited to, the following:

- doctors' visits
- ambulance and hospital services
- prescription drugs and certain over-the-counter prescription medications
- durable medical equipment
- dental care
- acupuncture
- chiropractic services
- COBRA health care continuation coverage
- qualified long-term care services and limited long-term care premiums
- dental care and vision care
- health insurance premiums for individuals receiving unemployment compensation
- at age 65 and over, Medicare Part A and B, Medicare HMO, and a member's share of employer-sponsored health insurance premiums (but not Medicare Supplement premiums)

A medical expense is not a qualified expense if a member receives reimbursement for it under insurance coverage. If the member's expense is paid for or reimbursed by an HSA account, that expense cannot be included for purposes of determining itemized tax deductions.

Service area

A service area is a designated geographic area covered by a member's health plan.