Kaiser Permanente Plus™ Frequently asked questions

Why are we bringing the Kaiser Permanente Plus (KP Plus) plan to market?

KP Plus expands our access in the market by making our products and integrated care available to more people while providing choice, flexibility, and affordability.

How are KP Plus plans different from other Kaiser Permanente plans?

Competitively priced KP Plus plans give employees access to top-rated care from Kaiser Permanente physicians and facilities, as well as affiliated providers. Plus, they offer the flexibility to receive a limited number of physician visits, outpatient medical services, and prescription fills or refills from out-of-network providers each year (limits vary by region and group size).

Do other carriers have similar products?

Since other carriers can't offer access to Kaiser Permanente practitioners, there are no similar products in the market.

Who would choose KP Plus plans and why?

KP Plus plans will appeal to employees who:

- Have established out-of-network doctor relationships
- Want medical options outside of Kaiser Permanente
- Need access to care outside their Kaiser Permanente service area
- Have been hesitant to commit to a traditional health care plan
- May be interested in Kaiser Permanente but have concerns about choice

Where are KP Plus plans available?

KP Plus is available for small and large businesses in all Kaiser Permanente areas, including California, Colorado, Georgia, Hawaii, Northwest, Mid-Atlantic States, and Washington.

Are these products available to all members?

Members must live or work in the Kaiser Permanente service area to be eligible for KP Plus. Out-of-network benefits can be used anywhere in the U.S. and its territories.

KP Plus is available to commercial, Multi-State, and national account plan members. It isn't currently available for Medicare and individual and family plan members.

Are KP Plus plans the same in all Kaiser Permanente regions?

Generally, the plan works similarly across regions. However, benefits may vary slightly. Refer to the plan's *Evidence of Coverage* for more details.

Are these plans compatible with financial accounts such as a health reimbursement arrangement (HRA), flexible spending account (FSA), or health savings account (HSA)?

KP Plus isn't HSA-compatible. But it's compatible with:

- HRA 213(d) limited purpose
- Dependent Care FSAs
- Medicare

What do KP Plus members need to know about out-of-network billing and payment?

Providers aren't obligated to submit a bill for services directly to Kaiser Permanente, but some may. If a provider doesn't submit a bill for services, members must pay for the visit upfront and submit a paper or online reimbursement form to Kaiser Permanente.

Are referrals or preauthorizations needed for out-of-network care?

KP Plus members don't need a referral or prior authorization to receive care out of network.

How are out-of-network visits or medical services counted?

Any medical service that's rendered out of network is counted as a visit. Multiple services in the same office setting on the same day may count as multiple visits and accrue toward the annual limits. For example, if a KP Plus member sees an out-of-network specialist, and that specialist orders one lab and one X-ray during the visit, that may count as 3 visits.

What happens if a KP Plus member exceeds the annual visit or prescription limit?

The member will have to pay out of pocket for any additional out-of-network services. The member still has access to comprehensive in-network care for the remainder of the year.

Where can KP Plus members find out how many out-of-network visits or medical services and prescription fills they have left?

Visits will be tracked in their accounts on kp.org. Members can also call the number on their Kaiser Permanente ID cards for a current total.

Are the out-of-network visits and prescriptions allotted only to the KP Plus member? Can they be shared within a family?

KP Plus members and their dependents each receive the number of out-of-network doctor visits or outpatient medical services and prescription fills allowed under their plan, up to the annual limit.

What if a member needs emergency care?

KP Plus members have coverage for in-person emergency and urgent care when and where they need it, and they don't need a referral. The cost depends on their plan's benefits.

For KP Plus members, what does care from Kaiser Permanente include?

- Fixed out-of-pocket costs with set cost-share amounts for most covered services
- 24/7 virtual care by phone, video, or online
- Preventive care services, such as routine physicals, well-child visits, and certain screening tests, with a $0 copay
- 24/7 access to kp.org, including test and lab results, scheduling appointments, checking prescription status, and more

For KP Plus members, what does care from out-of-network providers include?

- Members have a limited number of doctor visits or outpatient medical services per year, including lab and radiology (specific limits vary by plan).
- Members have a limited number of prescription fills or refills per year (specific limits vary by plan).
- Charges from out-of-network providers and pharmacies don't count toward the out-of-pocket maximum, except in California.
- Some providers may require payment in full at the time of service.
- Members may be responsible for any amount billed above the amount the plan covers.
- Members don't need a referral or prior authorization to receive care.
- Some services – including inpatient care, outpatient surgery, maternity, and prenatal care – need to be performed only by Kaiser Permanente and affiliated providers. Refer to the plan's *Evidence of Coverage* for more details.