Kaiser Permanente Plus™

Frequently asked questions

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

KP Plus plans offer comprehensive coverage from Kaiser Permanente physicians and facilities, as well as affiliated providers. Plus, the option to see out-of-network providers for up to 10 physician visits or outpatient medical services, and 5 prescription fills, per year.

Competitively priced KP Plus plans give employees access to top-rated care from Kaiser Permanente and affiliated providers – and the flexibility to get care from out-of-network providers for a limited number of times each year, all in one plan.

Do other carriers have similar products?

Since other carriers do not 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 appeal to employees with established doctor relationships out-of-network and those who want medical options outside of Kaiser Permanente. KP Plus plans also appeal to employees who travel and need access to care outside the Kaiser Permanente service area.

Where are KP Plus plans available?

KP Plus plans are available for Georgia large groups on April 1, 2022 (effective date July 1, 2022), and small groups on September 1, 2022 (effective date January 1, 2023).

The same plan designs are currently available in 3 Kaiser Permanente regions – HMO Plus and DHMO Plus in the Mid-Atlantic States and Colorado, and HMO Flex in Hawaii.

Are these products available to in- and out-of-area 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.

Are there differences between KP Plus in Kaiser Permanente regions?

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

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

These products are HRA 213(d) limited purpose and compatible with Medicare and Dependent Care FSAs. They aren't HSA-compatible.

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.

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 2 labs 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?

Visits will be tracked on kp.org starting Q4 2022. Members can also call the number on their Kaiser Permanente ID cards for a current total.

Are the 10 visits and 5 prescriptions allotted only to the KP Plus member? Can they be shared within a family?

Each member with a KP Plus plan is allowed 10 combined out-of-network visits or medical services and 5 fills per year.

What if a member needs emergency care?

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

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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 or video.
- Preventive care services, such as routine physicals, well-child visits, and certain screening tests, with $0 copay.
- Anytime 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?

- Maximum 10 doctor visits or outpatient medical services per year, including lab and radiology.
- Maximum 5 prescription fills per year.
- Charges from out-of-network providers or pharmacies don't count toward the out-of-pocket maximum.
- Some providers may require payment in full at the time of service.
- Some services – including inpatient care, outpatient surgery, maternity, and prenatal care – are performed only by Kaiser Permanente and affiliated providers. Refer to a plan's *Evidence of Coverage* for more details.
- Members don't need a referral or prior authorization to receive care.

Contact your Kaiser Permanente representative to learn more about KP Plus plans.