



Kaiser Permanente Plus™ plans

Quality care when and where it works for you

With KP Plus, you get comprehensive care from Kaiser Permanente doctors and facilities.* Plus you have the option to see out-of-network providers for a limited number of services each year.

How KP Plus works



Pay a lower cost share – your coinsurance or copay – when you see Kaiser Permanente doctors and other participating providers.



See out-of-network providers for up to 10 outpatient medical services and 5 prescription fills per year.

*KP Plus is a health insurance product offered by Kaiser Foundation Health Plan of the Northwest.



All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Care from Kaiser Permanente doctors and other participating providers

- **Fixed out-of-pocket costs** with set cost share amounts for most covered services
- **Preventive care services**, such as routine physicals, well-child visits, and certain screening tests, with \$0 copay
- **Talk to a clinician by phone or video** with Kaiser Permanente 24/7 virtual care
- **Anytime access to kp.org**, including most test and lab results, scheduling routine appointments, checking prescription status, and more
- **A deductible may or may not apply**, depending on your plan²



¹With one exception: Cost shares you pay for out-of-network services you receive under the Out-of-Area Coverage for Dependents benefit **do** apply to the in-network out-of-pocket maximum.

²Refer to your plan's *Evidence of Coverage* for more details.

Care from out-of-network providers

- **Maximum of 10 outpatient medical services per year, combined**, including preventive care services, lab, and radiology
- **Maximum 5 prescription fills** per year
- **There is no out-of-network deductible or out-of-pocket maximum**
- **Cost shares you pay for out-of-network services** do not apply to the in-network out-of-pocket maximum¹
- **Some providers** may require payment in full at the time of service, and you'd need to submit a claim for reimbursement. When using an out-of-network provider, you may be responsible for the amount you are billed above the maximum allowable charge by your plan.
- **Some services** – including inpatient care, outpatient surgery, and maternity care – are only covered when received from Kaiser Permanente doctors and other participating providers²
- **You don't need a referral** or prior authorization to get care
- **Get care from out-of-network providers when traveling** outside the Kaiser Permanente service area and within the Kaiser Permanente service area
- **Emergency services** you receive from out-of-network providers are covered at the in-network cost share and are not counted toward the limit of 10 services per year
- **Track your services** via Kaiser Permanente automated texts or voicemails you'll receive after your first and last visit or prescription fill. You can also call customer service for an update at **1-866-616-0047** or log in to your member account at **kp.org** to check your current out-of-network service accumulations.

Optimizing your out-of-network KP Plus benefits

In this example, you develop a severe case of the flu and visit a provider who is out-of-network. In addition to your office visit, the provider orders two lab tests and directs you to an out-of-network lab. You are also given a prescription for a flu medication.

Here are 2 options you could consider with a KP Plus plan:

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OPTION 1: 100% out-of-network services



Out-of-network provider office visit:

- You pay the higher cost share
- Visit counts as 1 service toward the 10-service limit



Out-of-network lab service (2 labs):

- You pay the higher cost share
- The lab tests count as up to 2 services toward the 10-service limit



Out-of-network pharmacy fill:

- You pay the higher cost share
- The prescription fill counts as 1 fill toward your 5-fill limit

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OPTION 2: Combined in-network and out-of-network services



Out-of-network provider office visit:

- You pay the higher cost share
- Visit counts as 1 service toward the 10-service limit



You bring the lab orders to a Kaiser Permanente medical office (2 labs):

- You pay the lower cost share
- The lab tests do not count toward your 10-service limit



You bring the prescription to a Kaiser Permanente pharmacy:

- You pay the lower cost share
- The prescription fill does not count toward your 5-fill limit

RESULT:



Overall, you pay a higher cost share for your covered services, and you use up to 3 of your 10 out-of-network services, and 1 of your 5 out-of-network prescription fills.



Overall, you pay a lower cost share for your covered services, and you use only 1 of your 10 out-of-network services, and none of your 5 out-of-network prescription fills.

Glossary

Balance billing – When a provider bills you for the difference between what they charge and the maximum amount allowed by your plan. For example, if a provider’s charge for a service is \$120 and the amount allowed by your plan is \$100, the provider may bill you for the remaining \$20.

Coinsurance – A percentage of the charges you pay for covered services. For example, a 20% coinsurance for a \$200 procedure means you’d pay \$40.

Copay – A set amount of money you pay for covered services. For example, a \$20 copay for an office visit, or a \$10 copay for generic prescription drugs.

Deductible – The amount of money you pay for covered services each year before your health plan provides those services at a copay or coinsurance.

Out-of-pocket maximum – The maximum amount of out-of-pocket expenses you pay for certain services. Once reached, covered services are paid at 100% for the rest of the calendar year.