

Arlington Public Schools FAQ

Considering Kaiser Permanente health coverage

Planning ahead can make a coverage change easier. Review your doctors, medications, appointments, and active treatments before enrolling, then ask about the support available for your specific needs.

About Kaiser Permanente

1. What is Kaiser Permanente?

Kaiser Permanente brings health coverage, doctors, specialists, pharmacies, and care coordination together in one system. Your care team can work together across services to support your health.

2. What should I review before choosing a plan?

Consider your current doctors, preferred medical locations, prescriptions, scheduled procedures, ongoing treatment, and the needs of each covered family member. Compare those needs with the official APS plan materials and provider information.

Transition and continuity of care

3. What does “transition of care” mean?

Transition of care is support provided when you move from one health plan or care system to another. The goal is to help you understand next steps for doctors, appointments, prescriptions, and ongoing treatment.

4. What is continuity of care?

Continuity of care generally refers to arrangements that may help an eligible member continue certain active treatment with a current provider for a limited period while care is safely coordinated. Eligibility and terms depend on the member’s circumstances and the applicable plan rules.

5. When should I ask about continuity-of-care support?

Ask early if you or a covered family member is pregnant, receiving active cancer care, recovering from a recent surgery, scheduled for a procedure, receiving ongoing behavioral health treatment, using specialty medications, or managing a complex condition.

6. What should I do if I am in active treatment?

Before coverage begins, gather your provider names, contact information, upcoming appointment dates, current treatment plan, prescriptions, and relevant medical records. Contact the designated Kaiser Permanente enrollment or transition resource listed in the official APS materials to request an individual review.

7. Can I automatically keep a non-Kaiser Permanente doctor?

Do not assume that a non-Kaiser Permanente provider will remain covered. Ask whether the provider participates in the applicable plan and whether your situation may qualify for temporary continuity-of-care consideration.

8. What if I am pregnant?

Ask how prenatal, maternity, and hospital care will be coordinated. Share your expected delivery date, current provider, hospital, and any high-risk care needs when requesting transition assistance.

9. What if I have surgery or a procedure scheduled?

Ask whether the procedure, facility, provider, prior authorization, and follow-up care will be covered after the new plan begins. Request a review before the effective date whenever possible.

Prescriptions

10. What should I do about current prescriptions?

Create a complete list of medications, dosages, prescribing doctors, and refill dates. Ask whether each medication is covered and whether a new prescription, clinical review, or pharmacy transfer is required.

11. What if I use a specialty medication?

Contact the designated pharmacy or transition resource early. Ask about coverage, authorization requirements, refill timing, delivery or pickup options, and how to avoid an interruption.

Enrollment and support

12. How can I prepare before coverage begins?

Your enrollment period is October 1 through October 31. Complete enrollment on time, review the official benefits and provider information, identify transition needs, refill time-sensitive medications as appropriate, collect medical information, select a doctor when instructed, and register for available digital tools after eligibility is active.

Questions? Let's talk.

Connect with a Kaiser Permanente advisor to learn more:
855-539-4197 (TTY 711), Monday through Friday, 10 a.m. to 9 p.m.

Visit myhealth.kp.org/apsva
for more information.

Important: This FAQ is a planning aid and does not replace the official APS plan documents, *Evidence of Coverage*, provider directory, formulary, or individual clinical review. Benefits, eligibility, network status, and continuity-of-care decisions are governed by the final plan terms and the member's circumstances.

