Changes to 2021 Benefits

District of Columbia—HSA Qualified High Deductible Health Plan (HDHP)

Small employer group changes for contracts renewing on or after January 1, 2021

This document provides an overview of changes Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is making to your small group HDHP health plan offerings effective upon your group's 2021 renewal date.

The following changes apply to all HDHP plans unless otherwise noted:

- **Plan Names:**
  - The word "**Dental**" has been removed from all plan names and replaced with the word **"Vision"**
- **Labs & Screenings:** The following labs and retinopathy screening will be covered at no charge
  - Retinopathy screening for the chronic condition of diabetes
  - Hemoglobin A1c testing for the chronic condition of diabetes
  - Low-density lipoprotein (LDL) testing for the chronic condition of heart disease
  - International Normalized Ratio (INR) testing for the chronic condition of liver disease and/or bleeding disorders
- **Durable Medical Equipment (DME):**
  - Peak Flow Meter – No longer subject to the deductible, applicable cost share still applies
- **Diabetic Equipment and Supplies:**
  - Glucose Monitoring Equipment (including test strips, lancets and control solution) - No longer subject to the deductible, applicable cost share still applies

For more information, please refer to your *Summary of Benefits and Coverage* (SBC) and/or your *Evidence of Coverage* (EOC).

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- **Dental Services:**
  - Adult $30 Preventive and Cosmetic Dental Plan has been discontinued
  - Pediatric Dental Plan (formerly Pediatric and Cosmetic Dental Plan) – Cosmetic services are no longer covered under pediatric dental benefits

The changes outlined below apply to the specified health plans as follows:

- **KP DC Gold 1700/0%/HSA/Vision (formerly KP DC Gold 1700/0%/HSA/Dental)**
  - Self-Only Out-of-Pocket Maximum: decreased from $6,650 to $5000 per individual
  - Family Out-of-Pocket Maximum: decreased from $13,300 to $10,000 per family (not to exceed $5,000 for any one family member)
  - Inpatient Hospital Services: changed from no charge per admission after deductible to $100 per admission after deductible
  - Outpatient Surgery Facility/Outpatient Hospital: changed from no charge after deductible to $100 per visit after deductible
  - Emergency Room: copay per visit decreased from $400 after deductible to $200 after deductible
  - The following benefits changed from no charge after deductible to Applicable cost share based on type and place of service
    - Accidental Dental Injury Services
    - Anesthesia for Dental Services
    - Cleft Lip, Cleft Palate or Both
    - Clinical Trials
    - Drugs, Supplies and Supplements
    - Family Planning - Male Sterilization and Voluntary Termination of Pregnancy
    - Hearing Services
    - Outpatient Delivery and All Services
    - Morbid Obesity Services including Bariatric Surgery
    - Oral Surgery including Treatment of the Temporomandibular Joint
    - Reconstructive Surgery
    - Infusion Therapy
    - Transplant Services

For more information, please refer to your *Summary of Benefits and Coverage* (SBC) and/or your *Evidence of Coverage* (EOC).

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Prescription Drugs:

- Preferred Brand Drugs:
  - Plan Pharmacy and Mail Delivery: copay per 30-day prescription decreased from $50 after deductible to $45 after deductible
  - Participating Network Pharmacy: copay per 30-day prescription decreased from $60 after deductible to $55 after deductible

- **KP DC Silver 2000/30/HSA/Vision (formerly KP DC Silver 2000/30/0%/HSA/Dental)**
  - Self-Only Out-of-Pocket Maximum: increased from $6,550 to $6,700 per individual
  - Family Out-of-Pocket Maximum: increased from $13,100 to $13,400 per family (not to exceed $6,700 for any one family member)

- **KP DC Silver 2500/30/HSA/Vision (formerly KP DC Silver 2500/30/0%/HSA/Dental)**
  - Self-Only Out-of-Pocket Maximum: increased from $6,700 to $7,000 per individual
  - Family Out-of-Pocket Maximum: increased from $13,400 to $14,000 per family (not to exceed $7,000 for any one family member)
  - Outpatient Surgery Physician/Surgical Services: copay increased from $40 after deductible to $50 after deductible

- **KP DC Bronze 6900/50/20%/HSA/Vision (formerly KP DC Bronze 5750/30/20%/HSA/Dental)**
  - Self-Only Deductible: increased from $5,750 to $6,900 per individual
  - Family Deductible: increased from $11,500 to $13,800 per family (not to exceed $6,900 for any one family member)
  - Self-Only Out-of-Pocket Maximum: increased from $6,550 to $7,000 per individual
  - Family Out-of-Pocket Maximum: increased from $13,100 to $14,000 per family (not to exceed $7,000 for any one family member)
  - Primary Office Visit: copay per visit increased from $30 after deductible to $50 after deductible
  - Copay per visit increased from $30 after deductible to $50 after deductible for the following benefits:
    - Applied Behavioral Analysis (ABA)
    - Medical Nutrition Therapy and Counseling
    - Mental Health Outpatient Office Visit
    - Vision Services: Optometrist – Routine Eye Exam
    - Specialty Office Visit: copay per visit increased from $50 after deductible to $70 after deductible

For more information, please refer to your *Summary of Benefits and Coverage* (SBC) and/or your *Evidence of Coverage* (EOC).

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- Copay per visit increased from $50 after deductible to $70 after deductible for the following benefits:
- Dialysis
- Routine Foot Care
- Therapy: Outpatient Radiation and Chemotherapy
- Urgent Care Centers or Facilities
- Vision Services: Ophthalmologist
- Sleep Studies

Prescription Drugs:

- Generic Drugs:
  - Plan Pharmacy and Mail Delivery: copay per 30-day prescription increased from $10 after deductible to $25 after deductible
  - Participating Network Pharmacy: copay per 30-day prescription increased from $20 after deductible to $35 after deductible
- Preferred Brand Drugs:
  - Plan Pharmacy and Mail Delivery: copay per 30-day prescription increased from $40 after deductible to $45 after deductible
  - Participating Network Pharmacy: copay per 30-day prescription increased from $50 after deductible to $55 after deductible
- Non-Preferred Brand Drugs:
  - Plan Pharmacy and Mail Delivery: copay per 30-day prescription decreased from $75 after deductible to $65 after deductible
  - Participating Network Pharmacy: copay per 30-day prescription decreased from $85 after deductible to $75 after deductible

- **KP DC Bronze 7000/0%/HSA/Vision (formerly KP DC Bronze 6550/0%/HSA/Dental)**
  - Self-Only Deductible: increased from $6,550 to $7000 per individual
  - Family Deductible: increased from $13,100 to $14,000 per family (not to exceed $7,000 for any one family member)
  - Self-Only Out-of-Pocket Maximum: increased from $6,550 to $7,000 per individual
  - Family Out-of-Pocket Maximum: increased from $13,100 to $14,000 per family (not to exceed $7,000 for any one family member)

For more information, please refer to your *Summary of Benefits and Coverage* (SBC) and/or your *Evidence of Coverage* (EOC).

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Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-888-777-5536** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-777-5536** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-777-5536** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-777-5536**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-777-5536** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-777-5536** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-888-777-5536 (TTY: **711**)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-777-5536** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-777-5536（TTY:**711**）まで、お電話にてご連絡ください。

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-777-5536** (TTY: **711**).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-888-777-5536 (TTY: **711**) पर कॉल करें।

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-777-5536** (መስማት ለተሳናቸው: **711**).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: **711**) **1-888-777-5536** تماس بگیری

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-777-5536** (رقم هاتف الصم والبكم: -**711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-777-5536** (TTY: **711**).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-777-5536** (ATS : **711**).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o.
E pe ero ibanisoro yi **1-888-777-5536** (TTY: **711**).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-777-5536** (TTY: **711**).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-777-5536** (TTY: **711**).

Bengali

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-888-777-5536** (TTY: **711**)।

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-888-777-5536** (TTY: **711**).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-777-5536** (TTY: **711**).

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-777-5536** (TTY: **711**).