

2021 RENEWAL PORTFOLIO | District of Columbia

Changes to 2021 Benefits

District of Columbia—POS

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 POS health plan offerings effective upon your group's 2021 renewal date.

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

- **Plan Names:**
 - The word “**Dental**” has been removed from all plan names and replaced with the word “**Vision**”

The following changes are applicable In-Plan Only:

- **Expanded Preventive Care Services:** 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)*.

kp.org/choosebetter



- **Vision Services:**

- Discount for Frames and Lenses changed from 40% discount off retail price to \$125 discount off retail price (discount is combined for frames and lenses and available once per year (365 days) and not available if contact lenses are purchased in lieu of frames and lenses)
- Discount for Contact Lenses changed 15% discount off retail price to \$25 discount off retail price, once per year (365 days) and not available if frames and lenses are purchased in lieu of contact lenses

- **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 1000/20/POS/Vision (formerly KP DC Gold 1000/20/POS/Dental)**

In-Plan Changes:

- Self-Only Out-of-Pocket Maximum: increased from \$6,500 to \$6,750 per individual
- Family Out-of-Pocket Maximum: increased from \$13,000 to \$13,500 per family (not to exceed \$6,750 for any one family member)
- Outpatient Surgery Physician/Surgical Services: copay per visit increased from \$50 after deductible to \$60 after deductible
- Emergency Room: copay per visit increased from \$350 after deductible to \$400 after deductible
- Specialty Imaging (MRI/CT/PET, etc.): copay per test increased from \$300 after deductible to \$350 after deductible
- Sleep Lap and Interventional Radiology: copay per visit increased from \$300 after deductible to \$350 after deductible

Prescription Drugs:

- Rx Deductible: increased from \$250 per member to \$300 per member
- Preferred Brand Drugs:
 - Plan Pharmacy and Mail Delivery: copay per 30-day prescription increased from \$50 after Rx deductible to \$60 after Rx deductible
 - Participating Network Pharmacy: copay per 30-day prescription increased from \$60 after Rx deductible to \$60 after Rx deductible

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

kp.org/choosebetter



deductible to \$70 after Rx deductible

Out-of-Network changes:

- There are no changes to out-of-network cost shares

• KP DC Bronze 6500/55/POS/Vision (formerly KP DC Bronze 6150/50/POS/Dental)

In-Plan Changes:

- Self-Only Deductible: increased from \$6,150 to \$6,500 per individual
- Family Deductible: increased from \$12,300 to \$13,000 per family (not to exceed \$6,500 for any one family member)
- Self-Only Out-of-Pocket Maximum: increased from \$8,150 to \$8,550 per individual
- Family Out-of-Pocket Maximum: increased from \$16,300 to \$17,100 per family (not to exceed \$8,550 for any one family member)
- Skilled Nursing Facility: Copay decreased from \$500 per day not to exceed \$1,500 per admission after deductible to \$300 per day not to exceed \$900 per admission after deductible
- Outpatient Surgery Facility/Outpatient Hospital: copay per visit decreased from \$350 after deductible to \$200 after deductible
- Primary Office Visit: Copay per visit increased from \$50 to \$55
- Copay per visit increased from \$50 to \$55 for the following benefits:
 - Applied Behavioral Analysis (ABA)
 - Medical Nutrition Therapy & Counseling
 - Mental Health Outpatient Office Visits and All Other Outpatient Services (when not performed as part of an office visit)
 - Vision Services: Optometrist – Routine Eye Exam
- X-ray and Diagnostic imaging: copay per visit increased from \$80 after deductible to \$200 after deductible

Prescription Drugs:

- Rx Deductible: increased from \$500 per member to \$750 per member
- Generic Drugs:
 - Plan Pharmacy and Mail Delivery: copay per 30-day prescription increased from \$30 to \$35
 - Participating Network Pharmacy: copay per 30-day prescription increased from \$40 to \$45
- Preferred Brand Drugs:

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

kp.org/choosebetter



- Plan Pharmacy and Mail Delivery: copay per 30-day prescription increased from \$80 after Rx deductible to \$100 after Rx Deductible
- Participating Network Pharmacy: copay per 30-day prescription increased from \$90 after Rx deductible to \$110 after Rx Deductible

Out-of-Network changes:

- Self-Only Deductible: increased from \$12,200 to \$13,000 per individual
- Family Deductible: increased from \$24,400 to \$26,000 per family (not to exceed \$13,000 for any one family member)
- Self-Only Out-of-Pocket Maximum: increased from \$16,400 to \$17,100 per individual
- Family Out-of-Pocket Maximum: increased from \$32,800 to \$34,200 per family (not to exceed \$17,100 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)*.

kp.org/choosebetter



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>.

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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚስተኛው 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 بگیرید

Arabic

ملحوظة: إذا كنت تتحدث اذکر 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 করুন: 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).