Changes to 2022 Benefits

Virginia—DHMO

Small employer group changes for contracts renewing on or after January 1, 2022

This document provides an overview of changes Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is making to your small group DHMO health plan offerings effective upon your group’s 2022 renewal date.

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

Allergy Treatment
- The cost share changed from “applicable cost share applies based on type and place of service” to the specialty office visit cost share.

Allergy Serum Injections
- The cost share changed from “applicable cost share applies based on type and place of service” to the primary care office visit cost share.

Autism Spectrum Disorder (ASD)
- Applied Behavioral Analysis (ABA) – All On-Exchange plans now include coverage for ABA services. The cost share follows the plan Primary Care office visit cost share.

Maternity Services
- The cost share for deliveries in a birthing center changed from “applicable cost share applies based on type and place of service” to the inpatient hospital cost share.

Vision Services
- Discount for contact lenses changed from $25 discount off retail price to $125 discount off retail price, once per year (365 days)

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

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Voluntary Termination of Pregnancy

- All On-Exchange plans now include coverage for voluntary abortion services. The cost share is based on type and place of service.

Prescription Drugs

- Generic, Preferred Brand, Non-Preferred, and Specialty drug tier descriptions changed as listed below:
  - Tier 1 Drugs: includes commonly prescribed generic drugs
  - Tier 2 Drugs: includes commonly prescribed brand-name drugs and commonly prescribed higher-cost generic drugs
  - Tier 3 Drugs: includes all other brand-name drugs that are on the formulary list and not included in Tier 1 or Tier 2. A limited number of generic drugs may also be included in Tier 3
  - Tier 4 Drugs: drugs that meet the criteria of Specialty Drugs and will not exceed cost-sharing of $300 for a thirty (30)-day supply

Manufacturer Prescription Drug Copay Coupon

- Manufacturer coupons can be used as payment for the cost sharing as allowed under health plan’s coupon program for outpatient prescription drugs and/or items that are covered under the Outpatient Prescription Drug Benefit. The dollar value of the manufacturer coupon will apply toward copay, coinsurance, deductible, and out-of-pocket maximum.

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

KP VA Platinum 500/20/Vision

- Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – copay per visit decreased from $30 to $20

- Prescription Drugs
  - Mail delivery copays decreased as follows:
    - Tier 1 Drugs: copay per 90-day prescription decreased from $10 to $8
    - Tier 2 Drugs: copay per 90-day prescription decreased from $50 to $38
    - Tier 3 Drugs: copay per 90-day prescription decreased from $100 to $75

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

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KP VA Gold 500/20/Vision

- Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – copay per visit decreased from $40 to $20

- Prescription Drugs
  - Mail delivery copays decreased as follows:
    - Tier 1 Drugs: copay per 90-day prescription decreased from $40 to $30
    - Tier 2 Drugs: copay per 90-day prescription decreased from $100 to $75
    - Tier 3 Drugs: copay per 90-day prescription decreased from $200 to $150

KP VA Gold 1000/20/Vision

- Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – copay per visit decreased from $50 to $20

- Prescription Drugs
  - Mail delivery copays decreased as follows:
    - Tier 1 Drugs: copay per 90-day prescription decreased from $40 to $30
    - Tier 2 Drugs: copay per 90-day prescription decreased from $100 to $75
    - Tier 3 Drugs: copay per 90-day prescription decreased from $200 to $150

KP VA Gold 1500/20/Vision

- Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – copay per visit decreased from $50 to $20

- Prescription Drugs
  - Mail delivery copays decreased as follows:
    - Tier 1 Drugs: copay per 90-day prescription decreased from $40 to $30
    - Tier 2 Drugs: copay per 90-day prescription decreased from $100 after Rx deductible to $75 after Rx deductible
    - Tier 3 Drugs: copay per 90-day prescription decreased from $200 after Rx deductible to $150 after Rx deductible

KP VA Silver 1750/40/Vision (formerly KP VA Silver 2000/40/Vision)

- Self-Only Deductible: decreased from $2,000 to $1,750 per individual
- Family Deductible: decreased from $4,000 to $3,500 per family (not to exceed $1,750 for any one family member)
- Self-Only Out-of-Pocket Maximum: increased from $8,550 to $8,700 per individual

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

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• Family Out-of-Pocket Maximum: increased from $17,100 to $17,400 per family (not to exceed $8,700 for any one family member)

• Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – copay per visit decreased from $60 after deductible to $40, deductible does not apply

• Prescription Drugs
  • Mail delivery copays decreased as follows:
    o Tier 1 Drugs: copay per 90-day prescription decreased from $40 to $30
    o Tier 2 Drugs: copay per 90-day prescription decreased from $120 after Rx deductible to $90 after Rx deductible

KP VA Silver 2750/30/Vision
• Self-Only Out-of-Pocket Maximum: increased from $8,550 to $8,700 per individual

• Family Out-of-Pocket Maximum: increased from $17,100 to $17,400 per family (not to exceed $8,700 for any one family member)

• X-ray and Diagnostic Imaging and Lab Services: copay per visit decreased from $60 after deductible to $60, deductible does not apply

• Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – The copay per visit decreased from $60 after deductible to $30, deductible does not apply

• Prescription Drugs
  • Mail delivery copays decreased as follows:
    o Tier 1 Drugs: copay per 90-day prescription decreased from $40 to $30
    o Tier 2 Drugs: copay per 90-day prescription decreased from $100 after Rx deductible to $75 after Rx deductible

KP VA Bronze 6500/50/Vision (formerly KP VA Bronze 7000/50/Vision)
• Self-Only Deductible: decreased from $7,000 to $6,500 per individual

• Family Deductible: decreased from $14,000 to $13,000 per family (not to exceed $6,500 for any one family member)

• Self-Only Out-of-Pocket Maximum: increased from $8,550 to $8,700 per individual

• Family Out-of-Pocket Maximum: increased from $17,100 to $17,400 per family (not to exceed $8,700 for any one family member)

• Autism Spectrum Disorder: Physical Therapy/Occupational Therapy/Speech Therapy – The copay per visit decreased from $100 after deductible to $50, deductible does not apply

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

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2021SG1435 MAS 9/27/21-12/31/22
• Specialist Office Visit: copay per visit decreased from $100 after deductible to $100, deductible does not apply.

• Copay per visit decreased from $100 after deductible to $100, deductible does not apply for the following benefits:
  o Dialysis
  o Private-duty nursing
  o Routine foot care
  o Therapy: radiation and chemotherapy
  o After-hours urgent care or urgent care center
  o Vision services: ophthalmologist
  o Sleep studies

• Prescription Drugs:
  • Rx Deductible: changed from $750 per member to medical deductible
  • Mail-order copays decreased as follows:
    o Tier 1 Drugs: copay per 90-day prescription decreased from $70 to $53
    o Tier 2 Drugs: copay per 90-day prescription changed from $160 after Rx deductible to $120 after deductible

KP VA Bronze 8700/0%/Vision (formerly KP VA Bronze 7000/40%/Vision)
• Self-Only Deductible: increased from $7,000 to $8,700 per individual
• Family Deductible: increased from $14,000 to $17,400 per family (not to exceed $8,700 for any one family member)
• Self-Only Out-of-Pocket Maximum: increased from $8,550 to $8,700 per individual
• Family Out-of-Pocket Maximum: increased from $17,100 to $17,400 per family (not to exceed $8,700 for any one family member)
• The cost shares changed from plan copays and coinsurance to no charge after deductible for all benefits except the following, which changed from coinsurance to no charge:
  o Glucose Monitoring Equipment
  o Peak Flow Meters

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

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- 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

Tagalog

Korean

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

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
ይዘምት: የትግርኛ ከማህክmutations የትግርኛ ከማህክmutations ያችላል። የነጻ ሁพลجيب ያርጉታል። ያደርጉት የትግርኛ ከማህክmutations 1-888-777-5536 (ማህክmutations ከማህክmutations: 711).
If you speak Farsi, please call 1-888-777-5536 (TTY: 711).