2023 RENEWAL PORTFOLIO | DISTRICT OF COLUMBIA

Changes to 2023 Benefits

District of Columbia–DHMO Virtual Forward and Virtual Complete

Small employer group changes for contracts renewing on or after January 1, 2023

This document provides an overview of changes Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is making to your small group DHMO Virtual Forward and Virtual Complete health plan offerings effective upon your group's 2023 renewal date.

For more information, please see your renewal notice, renewal contract, or *Summary of Benefit Changes.*

The following changes apply to all Virtual Forward and Virtual Complete plans unless otherwise noted:

Prescription Drugs

- The list of prescription drugs covered under the health plan's prescription drug plan will close, thus requiring medical necessity for coverage of drugs not on the formulary.

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

KP DC Gold Virtual Complete 2000 (Formerly KP DC Gold Virtual Forward 2000)

- Self-Only Out-of-Pocket Maximum: increased from $5,000 to $6,100 per individual
- Family Out-of-Pocket Maximum: increased from $10,000 to $12,200 per family (not to exceed $6,100 for any one family member)

- The following changed from (No charge for the first primary care visit, Allergy injection and serum, Applied Behavioral Analysis (ABA) Services, Medical Nutrition Therapy and Counseling, Outpatient Psychiatric and Substance Abuse Services for Mental Health and Substance Abuse, and Eye exams/Optometry Services combined, then the $20 copay applies for all subsequent office visits or services) to ($20 copay, deductible does not apply for the first three primary care visits, Allergy injection and serum, Applied Behavioral Analysis (ABA) Services, Medical Nutrition Therapy and Counseling, Outpatient Psychiatric and Substance Abuse Services for Mental Health and Substance Abuse, and Eye exams/Optometry Services combined, then the $20 after deductible applies for all subsequent office visits or services)
- Inpatient Hospital Services and Skilled Nursing Facility: copay per admission changed from $500 after deductible to 20% after deductible
- Inpatient Physician and Surgical Fees: copay per admission changed from $55 after deductible to 20% after deductible
- Outpatient Surgery Facility/Outpatient Hospital: copay per visit changed from $250 after deductible to 20% after deductible
- Outpatient Surgery Physician/Surgical Services: copay per visit changed from $70 after deductible to 20% after deductible
- Emergency Services: copay per visit changed from $350 after deductible (waived if admitted to the hospital) to 20% after deductible
- Laboratory Outpatient and Professional Services: copay per visit changed from $50 after deductible to $50
- X-rays and Diagnostic Imaging: copay per visit changed from $50 after deductible to 20% after deductible
- Sleep Labs and Interventional Radiology: copay per visit changed from $300 after deductible to 20% after deductible
- Specialty Imaging: copay per test changed from $300 after deductible to 20% after deductible

- Member coinsurance changed from No charge after deductible to 20% after deductible for the following benefits:
  - Blood, Blood Products and Their Administration
  - Durable Medical Equipment, Prosthetics and Orthotics, TMJ Appliances
  - Medical Foods
  - Diabetic Equipment & Supplies
- Peak Flow Meters: cost share changed from No charge to 20%
- Mental Health Services and Substance Use Disorder Outpatient (other than office visits): copay per visit changed from $20 after deductible to 20% after deductible

Prescription Drugs

- Plan Pharmacy copays changed as follows:
  - Tier 1 Drugs: copay per 30-day prescription changed from $10 after deductible to $10 a nd 90-day changed from $20 after deductible to $20
  - Tier 2 Drugs: copay per 30-day prescription changed from $60 after deductible to 20% after deductible and 90-day changed from $120 after deductible to 20% after deductible
  - Tier 3 Drugs: copay per 30-day prescription changed from $100 after deductible to 20% after deductible and 90-day changed from $200 after deductible to 20% after deductible

- Participating Network Pharmacy copays changed as follows:
  - Tier 1 Drugs: copay per 30-day prescription changed from $20 after deductible to $20 and 90-day changed from $40 after deductible to $40
  - Tier 2 Drugs: copay per 30-day prescription changed from $70 after deductible to 20% after deductible and 90-day changed from $140 after deductible to 20% after deductible
  - Tier 3 Drugs: copay per 30-day prescription changed from $110 after deductible to 20% after deductible and 90-day changed from $220 after deductible to 20% after deductible

- Mail Order copays changed as follows:
  - Tier 1 Drugs: copay per 30-day prescription changed from $10 after deductible to $10
    and 90-day changed from $15 after deductible to $15
  - Tier 2 Drugs: copay per 30-day prescription changed from $60 after deductible to 20% after deductible and 90-day changed from
    $90 after deductible to 20% after deductible
  - Tier 3 Drugs: copay per 30-day prescription changed from $100 after deductible to 20% after deductible and 90-day changed from $150 after deductible to 20% after deductible

KP DC Silver Virtual Forward 3000

- Self-Only Out-of-Pocket Maximum: decreased from $8,700 to $8,650 per individual
- Family Out-of-Pocket Maximum: decreased from $17,400 to $17,300 per family (not to exceed $8,650 for any one family member)

Prescription Drugs

- Participating Network Pharmacy changed from covered to Not covered

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St. Rockville, MD 20852 2022SG1402 MAS 10/15/22-12/31/23

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan 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 **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan 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 by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Ðá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (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。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).