2023 RENEWAL PORTFOLIO | MARYLAND

Changes to 2023 Benefits

Maryland – 3 Tier Point-of-Service (3TPOS)

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., and Kaiser Permanente Insurance Company (KPIC)* are making to your small group 3TPOS health plan offerings effective upon your group's 2023 renewal date.

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

The following changes apply to all 3TPOS health plans unless otherwise noted:

Habilitative Services

- The thirty (30) visit limits removed from adults and age limit removed from Applied Behavioral Analysis (ABA) from children for habilitative services.

Prescription Insulin Drugs

- The cost share is no longer subject to the deductible and cannot exceed $30 per thirty (30)-day supply or $90 for a ninety (90)-day supply.

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

KP MD Gold Flexible Choice 0/20/3TPOS/Vision

- Self-Only Out-of-Pocket Maximum:
  - Option 1: increased from $4,200 per individual to $4,450 per individual

*Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the in-network tier (Option 1) and KPIC, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the out-of-network coverage consisting of the participating provider tier (Option 2) and the non-participating provider tier (Option 3) of the POS plan.

- Option 2: increased from $4,350 per individual to $4,650 per individual
- Option 3: increased from $8,700 per individual to $9,100 per individual

▶ Family Out-of-Pocket Maximum:

- Option 1: increased from $8,400 per family to $8,900 per family (not to exceed $4,450 for any one family member)
- Option 2: increased from $8,700 per family to $9,300 per family (not to exceed $4,650 for any one family member)
- Option 3: increased from $17,400 per family to $18,200 per family (not to exceed $9,100 for any one family member)

▶ Primary Care Office Visit:

- Option 2: copay per visit increased from $30 to $35

▶ Option 2: Copay per visit increased from $30 to $35 for the following benefits:

- Allergy Injection Visit and Serum
- Applied Behavioral Analysis (ABA)
- Medical Nutrition Therapy & Counseling
- Mental Health and Substance Abuse Services visits
- Telemedicine provided by the primary care provider
- Routine Eye Exam (Optometrist)
- Urgent Care Office visit

▶ Specialty Care Office Visit:

- Option 2: copay per visit increased from $50 to $55

▶ Option 2: Copay per visit increased from $50 to $55 for the following benefits:

- Allergy Services (evaluation & diagnosis) visit
- Dialysis
- Accidental Dental Injury Services – Office visit
- Fertility Services – Standard Fertility Preservation visit and procedure for Iatrogenic Infertility
- Hearing Testing and Fitting
- Routine Foot Care Visit
- Telemedicine services provided by the specialty care provider
- Therapy: Radiation and Chemotherapy Visit
- Urgent Care Centers or Facilities
- Vision Services: Ophthalmologist Visit
- Sleep Studies

- Laboratory Outpatient and Professional Services:
  - Option 1: copay per visit increased from $20 to $25
  - Option 2: copay per visit increased from $30 to $45
- X-rays and Diagnostic Imaging
  - Option 2: copay per visit increased from $50 to $60
- Therapy – Habilitative and Rehabilitation Services, Acupuncture & Chiropractic Services
  - Option 2: copay per visit increased from $50 to $60
- Outpatient Surgery Physician Services:
  - Option 2: copay per visit increased from $50 after deductible to $55 after deductible
- Abortion Care Services: Option 1, 2 and 3
  - The cost share changed from "applicable cost share applies based on type and place of service" to "No charge"

Prescription Drugs:

- Rx Deductible
  - Option 1 & 2: increased from $200 per member to $300 per member

KP MD Gold Flexible Choice 1000/20/3TPOS/Vision

- Self-Only Out-of-Pocket Maximum:
  - Option 1: increased from $4,200 per individual to $4,450 per individual
  - Option 2: increased from $4,350 per individual to $4,650 per individual
  - Option 3: increased from $8,700 per individual to $9,100 per individual
- Family Out-of-Pocket Maximum:
  - Option 1: increased from $8,400 per family to $8,900 per family (not to exceed $4,450 for any one family member)
  - Option 2: increased from $8,700 per family to $9,300 per family (not to exceed $4,650 for any one family member)
  - Option 3: increased from $17,400 per family to $18,200 per family (not to exceed $9,100 for any one family member)
- Primary Care Office Visit:
  - Option 2: copay per visit increased from $30 to $35
- Option 2: Copay per visit increased from $30 to $35 for the following benefits:
  - Allergy Injection Visit and Serum
  - Applied Behavioral Analysis (ABA)

- Medical Nutrition Therapy & Counseling
- Mental Health and Substance Abuse Services Visits
- Telemedicine provided by the primary care provider
- Routine Eye Exam (Optometrist)
- Urgent Care Office Visit

▶ Specialty Care Office Visit:

- Option 2: copay per visit increased from $50 to $55

▶ Option 2: Copay per visit increased from $50 to $55 for the following benefits:

- Allergy Services (Evaluation & Treatment) Visit
- Dialysis
- Accidental Dental Injury Services – Office Visit
- Fertility Services – Standard Fertility Preservation visit and procedure for Iatrogenic Infertility
- Hearing Testing and Fitting
- Routine Foot Care Visit
- Telemedicine services provided by the specialty care provider
- Therapy: Radiation and Chemotherapy Visit
- Urgent Care Centers or Facilities
- Vision Services: Ophthalmologist Visit
- Sleep Studies

▶ Laboratory Outpatient and Professional Services:

- Option 1: copay per visit increased from $20 to $25
- Option 2: copay per visit increased from $30 to $45

▶ X-rays and Diagnostic Imaging:

- Option 2: copay per visit increased from $50 to $60
- Therapy – Habilitative, Rehabilitation, Acupuncture and Chiropractic Services

▶ Outpatient Surgery Physician Services:

- Option 2: copay per visit increased from $50 after deductible to $55 after deductible

▶ Abortion Care Services: Option 1, 2 & 3

- The cost share changed from "applicable cost share applies based on type and place of service" to "No charge"

Prescription Drugs:

▶ Rx Deductible:

- Option 1: increased from $150 per member to $200 per member

KP MD Gold Flexible Choice 1500/0/HSA/3TPOS/Vision (formerly KP MD Gold Flexible Choice 1400/0/HSA/3TPOS/Vision)

- Self-Only Deductible:
  - Option 1: increased from $1,400 per individual to $1,500 per individual
  - Option 2: increased from $2,800 per individual to $3,000 per individual
- Family Deductible:
  - Option 1: increased from $2,800 for one or more family members combined to $3,000 for one or more family members combined
  - Option 2: increased from $4,000 per family to $4,500 per family (not to exceed $3,000 for any one family member)
- Self-Only Out-of-Pocket Maximum:
  - Option 2: increased from $3,600 per individual to $3,950 per individual
- Family Out-of-Pocket Maximum:
  - Option 2: increased from $7,200 per family to $7,900 per family (not to exceed $3,950 for any one family member)
- Inpatient Hospital Services & Skilled Nursing Facility Services:
  - Option 1: copay per admission increased from $150 after deductible to $200 after deductible
  - Option 2: copay per admission increased from $200 after deductible to $250 after deductible
- Emergency Services:
  - Option 1, 2 & 3: copay per visit increased from $300 after deductible to $350 after deductible
- Abortion Care Services: Option 1, 2 & 3
  - The cost share changed from "applicable cost share applies based on type and place of service" to "No charge after deductible"
- Manufacturer Prescription Drug Copay Coupon: Option 1
  - Approved manufacturer coupons can be used as payment for the cost sharing as allowed under the health plan's coupon program for outpatient prescription drugs and/or items that are covered under the Outpatient Prescription Drug Benefit. After the plan deductible is satisfied, the dollar value of the approved manufacturer coupon will apply toward copay, coinsurance, and out-of-pocket maximum.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St. Rockville, MD 20852 2022SG1403 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**).

Ɓǎsɔ́ɔ̀ 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. Ɖá **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**).