2023 RENEWAL PORTFOLIO | VIRGINIA

Changes to 2023 Benefits

Virginia—HSA Qualified High Deductible Health Plans (HDHP)

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 HDHP 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).

The following changes apply to all HDHP 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.*

Manufacturer Prescription Drug Copay Coupon

- *If permitted under the federal law, 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.*

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

KP VA Gold 1500/0%/HSA/Vision (formerly KP VA Gold 1400/0%/HSA/Vision)

- *Self-Only Deductible: increased from $1,400 to $1,500 per individual*
- *Family Deductible: increased from $2,800 per one or more family members combined to $3,000 per one or more family members combined*

KP VA Silver 2000/30/HSA/Vision

- *Self-Only Out-of-Pocket Maximum: increased from $6,000 to $6,650 per individual*
- *Family Out-of-Pocket Maximum: increased from $12,000 per family to $13,300 per family (not to exceed $6,650 for any one family member)*

KP VA Silver 3000/30/HSA/Vision

- *Self-Only Out-of-Pocket Maximum: increased from $6,000 to $6,650 per individual*
- *Family Out-of-Pocket Maximum: increased from $12,000 per family to $13,300 per family (not to exceed $6,650 for any one family member)*

KP VA Silver 4000/0%/HSA/Vision

- *Self-Only Out-of-Pocket Maximum: increased from $5,250 to $7,500 per individual*
- *Family Out-of-Pocket Maximum: increased from $10,500 per family to $15,000 per family (not to exceed 7,500 for any one family member)*
- *Emergency Room: copay per visit increased from $350 after deductible to $450 after deductible*

Prescription Drugs

- *Plan Pharmacy copays changed as follows:*
  - Tier 1 Drugs: copay per 30-day prescription increased from No charge after deductible to $20 after deductible and 90-day increased from No charge after deductible to $40 after deductible
  - Tier 2 Drugs: copay per 30-day prescription increased from $40 after deductible to $50 after deductible and 90-day increased from $80 after deductible to $100 after deductible
- *Participating Pharmacy copays changed as follows:*
  - Tier 1 Drugs: copay per 30-day prescription increased from $10 after deductible to $30 after deductible and copay per 90-day prescription increased from $20 after deductible to $60 after deductible
  - Tier 2 Drugs: copay per 30-day prescription increased from $50 after deductible to $60 after deductible and copay per 90-day prescription increased from $100 after deductible to $120 after deductible
- *Mail Order copays changed as follows:*
  - Tier 1 Drugs: copay per 30-day prescription increased from No charge after deductible to $20 after deductible and 90-day increased from No charge after deductible to $30 after deductible
  - Tier 2 Drugs: copay per 30-day prescription copay and 90-day increased from $60 after deductible to $75 after deductible

KP VA Bronze 6000/30/HSA/Vision (formerly KP VA Bronze 6000/30/20%/HSA/Vision)

- *Member Coinsurance: changed from 20% after deductible to the copays after deductible for the following benefits:*
  - Inpatient Hospital Services and Skilled Nursing Facility: cost share changed to $500 after deductible per admission
  - Inpatient Physician and Surgical Fees: cost share changed to $100 after deductible per admission

- Outpatient Facility Fee: cost share changed to $300 after deductible per visit
- Outpatient Surgery Physician Services: cost share changed to $100 after deductible per visit
- Emergency Room: cost share changed to $250 after deductible per visit
- Therapy: Habilitative, Rehabilitation, and Chiropractic services: cost share changed to $100 after deductible per visit
- Early Intervention Services: cost share changed to $100 after deductible per visit
- Pulmonary Rehabilitation: cost share changed to $100 after deductible per visit
- Laboratory Outpatient and Professional Services: cost share changed to $50 after deductible per visit
- X-rays and Diagnostic Imaging: cost share changed to $100 after deductible per visit
- Sleep Lab and Interventional Radiology: cost share changed to $500 after deductible per visit
- Specialty Imaging: cost share changed to $500 after deductible per test

▶ *The following benefits changed from 20% after deductible to No charge after deductible:*

- Blood, Blood Products and Their Administration
- Durable Medical Equipment, Prosthetics and Orthotics, TMJ Appliances
- Home Health Services
- Hospice Services
- Medical Foods
- Diabetic Equipment & Supplies

▶ *Glucose Monitoring Equipment and Supplies: cost share changed from 20% to No charge*

▶ *Peak Flow Meters: cost share changed from 20% to No charge*

KP VA Bronze 7000/0%/HSA/Vision (formerly KP VA Bronze 6850/0%/HSA/Vision)

- *Self-Only Deductible: increased from $6,850 to $7,000 per individual*
- *Family Deductible: increased from $13,700 to $14,000 per family (not to exceed $7,000 for any one family member)*
- *Self-Only Out-of-Pocket Maximum: increased from $6,850 to $7,000*
- *Family Out-of-Pocket Maximum: increased from $13,700 to $14,000 per family (not to exceed $7,000 for any one family member)*

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St. Rockville, MD 20852 2022SG1414 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-poò bɛ́ìn m̀ gbo kpáa. Đá **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**).