Changes to 2017 benefits

MARYLAND–HMO

Mid-large employer group changes for contracts renewing on or after January 1, 2017

This document provides an overview of changes Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is making to your large group HMO health plan offerings effective upon your group’s 2017 renewal date.

Your group may have elected other changes to existing plan design offerings that are not included in this summary, or additional modifications in cost share amounts may occur as a result of changes in employees’ plan selection. Please work with your account manager if you have questions regarding specific changes to your group’s plan offerings.

The following changes apply to all non-grandfathered large group HMO health plans unless otherwise specified:

- **Habilitative services**
  Benefit extends to the end of the month in which the child turns age 19 for medically necessary treatment therapies and Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorder.

- **Infertility services**
  Important legislation was passed by the Maryland legislature and enacted into law. Effective July 1, 2016, coverage for the treatment of infertility, including in vitro fertilization (IVF), will no
longer require that the patient’s spouse’s sperm be used for covered treatments or procedures. As required by the amended legislation, beginning on July 1, 2016, Kaiser Permanente will permit the use of donor sperm for fertilization procedures when members meet the criteria for IVF procedures.

Any costs associated with acquiring donor sperm are not covered and remain the responsibility of the member.

Members should follow the steps below to determine eligibility for IVF services:

• Demonstrate a history of involuntary infertility. A patient and the patient’s spouse may demonstrate a history of involuntary infertility if the patient and the patient’s spouse are of opposite sexes and intercourse of at least two years duration has failed to result in pregnancy, or, for same sex female couples, six attempts of artificial insemination over the course of two years has failed to result in pregnancy.

• Members who are eligible for IVF treatment should contact their ob/gyn to determine the medical necessity of the procedure. Once medical necessity and a history of involuntary infertility have been established, the ob/gyn will enter a referral or eConsult for the required procedure if care is received from a plan provider. Members using non-plan providers do not require a referral.

• Procedures must be performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists, or the American Society for Reproductive Medicine.

IVF procedures are subject to the applicable infertility cost share under the member’s plan. IVF coverage is subject to all the plan’s applicable terms, including a lifetime maximum dollar amount for such treatments.

kp.org/choosebetter