2017 Benefits at a Glance

Health Plans (Administrators)	**COVA Care** (Anthem)	**COVA HealthAware** (Aetna)	**COVA HDHP** (Anthem)	**Kaiser Permanente** (Kaiser)
Benefits	**You Receive**	**You Receive**	**You Receive**	**You Receive**
Health Reimbursement Arrangement (HRA) Employer deposit to your HRA on July 1, 2017	Not available	$600 employee $600 enrolled spouse	Not available	Not available
In-Network Benefits	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Deductible – per plan year				
• One person	$300	$1,500	$1,750	None
• Two or more persons	$600	$3,000	$3,500	None
Out-of-pocket expense limit – per plan year				
• One person	$1,500	$3,000	$5,000	$1,500
• Two or more persons	$3,000	$6,000	$10,000	$3,000
Doctor's visits (in person and telemedicine)				
• Primary care physician	$25	20% after deductible	20% after deductible	$25
• Specialist	$40	20% after deductible	20% after deductible	$40
Hospital services				
• Inpatient	$300 per stay	20% after deductible	20% after deductible	$300 per admission
• Outpatient	$125 per visit	20% after deductible	20% after deductible	$75 per visit
Emergency room visits	$150 per visit (waived if admitted)	20% after deductible	20% after deductible	$75 per visit (waived if admitted)
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	$50 per service
Outpatient diagnostic laboratory and x-rays	20% after deductible	20% after deductible	20% after deductible	$0 lab, pathology, shots, radiology, diagnostic tests $75 specialty imaging
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible	20% after deductible	$25 PCP $40 specialist
Outpatient therapy visits				
• Occupational and speech therapy	$25 PCP/$35 specialist	20% after deductible	20% after deductible	$40
• Physical therapy only	$15	20% after deductible	20% after deductible	$40
• Physical therapy and other related services, including manual intervention & spinal manipulation	$25 PCP/$35 specialist	20% after deductible	20% after deductible	$40
• Chiropractic services (30-visit plan year limit per member)	$25 PCP/$35 specialist	20% after deductible	20% after deductible	$40
Applied behavior analysis (ABA) for autism spectrum disorder–ages 2 through 10	$25 per service	20% after deductible	20% after deductible	$25 per visit
Behavioral health				
• Medical and non-medical professional visits	$25	20% after deductible	20% after deductible	$12 group/$25 individual
• Inpatient residential treatment	$300 per stay	20% after deductible	20% after deductible	$300 per admission
• Intensive outpatient treatment (IOP)	$125 per episode of care	20% after deductible	20% after deductible	$12 group/$25 individual
Employee Assistance Program (EAP) Up to 4 visits per incident	$0	$0	$0	$0
Prescription drugs – mandatory generic				
Retail Pharmacy	Up to 34-day supply $15/$30/$45/$55	Up to 34-day supply 20% after deductible	Up to 34-day supply 20% after deductible	Up to 30-day supply Medical center: $15/$25/$40 Community participating: $20/$45/$60 (3 x copayment for 90 days)
Home Delivery Pharmacy	Up to 90-day supply $30/ $60/$90/$110	Up to 90-day supply 20% after deductible	Up to 90-day supply 20% after deductible	Up to 30-day supply $13/$23/$38 (2 x copayment for 90 days)

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In-Network Benefits	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Wellness & preventive services				
• Office visits at specified intervals, immunizations, lab and x-rays	$0	$0	$0	$0
• Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays	$0	$0	$0	$0
• Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening	$0	$0	$0	$0
Annual Routine Vision Exam	*Optional benefit**	$0	Not available	$25 PCP/$40 specialist
Annual Routine Hearing Exam	*Optional benefit**	$0	Not available	$25 PCP/$40 specialist
Dental Services				
• Diagnostic and preventive	$0	$0	$0	See fee schedule
Expanded Dental	*Optional Benefit*:*	*Optional Benefit*:*	*Optional Benefit*:*	
• Maximum benefit – per member	$2,000	$2,000	$2,000	$1,000
• Deductible	$50/$100/$150	$50/$100/$150	$50/$100/$150	$25 per person
• Primary (basic) care	20% after deductible	20% after deductible	20% after deductible	See fee schedule
• Complex restorative (inlays, onlays, crowns, dentures, bridgework)	50% after deductible	50% after deductible	50% after deductible	See fee schedule
• Orthodontic - Lifetime maximum benefit	50% no deductible $2,000	50% no deductible $2,000	50% no deductible $2,000	See fee schedule $1,000 (age 19 and under)
Routine Vision	*Optional Benefit*:*	*Optional Benefit*:*		
• Routine eye exam (once every plan year)	$40	$0 (Included in basic plan)	Not available	$25 PCP/$40 Specialist
• Eyeglass frames	80% after plan pays $100	80% after plan pays $100	Not available	75% of balance
• Lenses				
- Eyeglass lenses (standard plastic, single, bifocal or trifocal) or	$20	$20	Not available	75% of balance
• Contact lenses**				
- Conventional**	85% after plan pays $100	85% after plan pays $100	Not available	85% for initial fitting and pair
- Disposable**	Balance after plan pays $100	Balance after plan pays $100	Not available	85% for initial fitting and pair
- Non-elective**	Balance after plan pays $250	Balance after plan pays $250	Not available	85% for initial fitting and pair Pediatric Eyewear -contact Kaiser
Routine Hearing	*Optional Benefit*:*			
• Routine hearing exam (once every plan year)	$40	$0 (Included in basic plan)	Not available	$25 PCP/$40 Specialist
• Hearing aids and other hearing-aid related services (once every 48 months)	Balance after plan pays $1,200	Not available	Not available	Not available
• Benefit maximum	$1,200	Not available	Not available	Not available
Out-of-Network	*Optional Benefit*:*	*Included in Basic Plan:*		
	Plan payment reduced by 25%. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 40% coinsurance after deductible of $3,000/$6,000. Balance billing may apply.	Not available	Not available

The program also offers the TRICARE voluntary supplement, which coordinates with federal TRICARE benefits.

*Optional benefits are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart.
**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

This is only an overview of your health care benefits. For details, see the appropriate Member Handbook or plan document, or ***www.dhrm.virginia.gov***.