# 2021 BENEFITS AT A GLANCE

| Health Plans | COVA Care | COVA HealthAware | COVA HDHP | Kaiser Permanente | Optima Health |
|---|---|---|---|---|---|
| **Benefits** | **You Receive** | **You Receive** | **You Receive** | **You Receive** | **You Receive** |
| **Health Reimbursement Arrangement (HRA)**<br>**Employer deposit to your HRA on July 1, 2021** | Not available | $600 employee<br>$600 enrolled spouse | Not available | Not available | Not available |
| **In-Network Benefits** | **You Pay** | **You Pay** | **You Pay** | **You Pay** | **You Pay** |
| **Deductible – per plan year** | | | | | |
| • One person | $300 | $1,500 | $1,750 | None | $150 |
| • Two or more persons | $600 | $3,000 | $3,500 | None | $300 |
| **Out-of-pocket expense limit – per plan year** | | | | | |
| • One person | $1,500 | $3,000 | $5,000 | $1,500 | $1,500 |
| • Two or more persons | $3,000 | $6,000 | $10,000 | $3,000 | $3,000 |
| **Doctor's visits** (in person and telemedicine) | | | | | |
| • Primary care physician | $25 | 20% after deductible | 20% after deductible | $25 | Tier 1: $5<br>Tier 2: $25 |
| • Telehealth physician visit | $0<br>www.livehealthonline.com | $0<br>www.teladoc.com/aetna | 20% after deductible<br>www.livehealthonline.com | $0<br>www.kp.org • 1-800-777-7904 | $0<br>MDLIVE 866-648-3638 |
| • Specialist | $40 | 20% after deductible | 20% after deductible | $40 | Tier 1: $10<br>Tier 2: $40 |
| **Hospital services** | | | | | |
| • Inpatient | $300 per stay | 20% after deductible | 20% after deductible | $300 per admission | $300 per admission |
| • Outpatient | $125 per visit | 20% after deductible | 20% after deductible | $75 per visit | $125 per visit |
| **Emergency room visits** | $150 per visit<br>(waived if admitted) | 20% after deductible | 20% after deductible | $75 per visit<br>(waived if admitted) | $150 per visit<br>(waived if admitted) |
| **Ambulance travel** | 20% after deductible | 20% after deductible | 20% after deductible | $50 per service | 20% after deductible |
| **Outpatient diagnostic laboratory and x-rays** | 20% after deductible | 20% after deductible | 20% after deductible | $0 lab, pathology, shots, radiology, diagnostic tests<br>$75 specialty imaging | 20% after deductible |
| **Infusion services (includes IV or injected chemotherapy)** | 20% after deductible | 20% after deductible | 20% after deductible | $25 PCP<br>$40 specialist | $40 copay per office visit<br>$100 copay for pre-authorized Injectable/Infused Medications |
| **Outpatient therapy visits** | | | | | |
| • Occupational and speech therapy | $25 PCP/$35 specialist | 20% after deductible | 20% after deductible | $40 (30 visits/episode) | $25* |
| • Physical therapy only | $15 | 20% after deductible | 20% after deductible | $40 (30 visits/episode) | $25* |
| • Physical therapy and other related services, including manual intervention & spinal manipulation | $25 PCP/$35 specialist | 20% after deductible | 20% after deductible | $40 (30 visits/episode) | $25* |
| • Chiropractic services (30-visit plan year limit per member) | $25 PCP/$35 specialist | 20% after deductible | 20% after deductible | $40 | $35 |
| **Autism spectrum disorder treatment and related services** | $25 per service | 20% after deductible | 20% after deductible | $25 per visit /$40 specialist | Tier 1: $5<br>Tier 2: $25 |
| **Behavioral health** | | | | | |
| • Medical and non-medical professional visits | $25 | 20% after deductible | 20% after deductible | $12 group/$25 individual | $10 |
| • Inpatient residential treatment | $300 per stay | 20% after deductible | 20% after deductible | $300 per admission | $300 per admission |
| • Intensive outpatient treatment (IOP) | $125 per episode of care | 20% after deductible | 20% after deductible | $12 group/$25 individual | $125 |
| **Employee Assistance Program (EAP)**<br>Up to 4 visits per incident | $0 | $0 | $0 | $0 | $0 |
| **Prescription drugs – mandatory generic** | | | | | |
| **Retail Pharmacy** | Up to 34-day supply<br>$15/$30/$45/$55 | 20% after deductible | 20% after deductible | Up to 30-day supply<br>KP center: $15/$25/$40<br>Specialty: 50%, $75 max<br>Community participating: $20/$45/$60<br>(3 x copayment for 90 days) | Up to 31-day supply<br>$15/$30/$45/$55 |
| **Home Delivery Pharmacy** | Up to 90-day supply<br>$30/$60/$90/$110 | 20% after deductible | 20% after deductible | $13/$23/$38<br>(2 x copayment for 90 days) | Up to 90-day supply<br>$30/$60/$90/$55** |

*Occupational and Physical therapy are limited to a maximum combined benefit of 30 visits per plan year. Speech therapy is limited to a maximum of 30 visits per plan year.
**31-day supply for Specialty Tier 4

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| **Wellness & Preventive Services** | | | | | |
| • Office visits at specified intervals, immunizations, lab and x-rays | $0 | $0 | $0 | $0 | $0 |
| • Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays | $0 | $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 | $0 |
| **Annual Routine Vision Exam** | $15 | $0 | $15 | $25 PCP/$40 specialist | $15 |
| **Annual Routine Hearing Exam** | *Optional benefit** | $0 | Not available | $25 PCP/$40 specialist | $40 |
| **Dental Services** | | | | | |
| • Diagnostic and preventive | $0 | $0 | $0 | $0 | $0 |
| **Expanded Dental** | *Optional Benefit*:* | *Optional Benefit*:* | *Optional Benefit*:* | *Included with Medical:* | *Included with Medical:* |
| • Maximum benefit – per member | $2,000 | $2,000 | $2,000 | $1,000 | $2,000 |
| • Deductible | $50/$100/$150 | $50/$100/$150 | $50/$100/$150 | $25 per person/$75 family | $50/$150 |
| • Primary (basic) care | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| • Complex restorative (inlays, onlays, crowns, dentures, bridgework) | 50% after deductible | 50% after deductible | 50% after deductible | 50% after deductible | 50% after deductible |
| • Orthodontic<br>- Lifetime maximum benefit | 50% no deductible<br>$2,000 | 50% no deductible<br>$2,000 | 50% no deductible<br>$2,000 | 50% up to $1,000 (age 19 and under) | 50% no deductible<br>$2,000 |
| **Routine Vision - Basic Plan** | *Included with Medical:* | *Included with Medical:* | *Included with Medical:* | *Included with Medical:* | *Included with Medical:* |
| • Annual Routine Vision Exam | $15 | $0 | $15 | $25 PCP/$40 specialist | $15 |
| • Eyeglass frames | 80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses | 65% of the retail price | 80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses | Balance after plan pays $75 (age 19+)<br><19 $0 (1 pair/plan year) | 80% after plan pays $100 |
| • Eyeglass lenses - standard plastic<br>- Single<br>- Bifocal<br>- Trifocal | <br>$50<br>$70<br>$105 | <br>$40<br>$60<br>$80 | <br>$50<br>$70<br>$105 | Balance after plan pays $75 (age 19+)<br><19 $0 (1 pair/plan year) | $20 |
| • Contact lenses**<br>- Conventional**<br>- Disposable**<br>- Non-elective** | Conventional contact lenses: 85% of the retail price (discount applies to materials only) | Conventional contact lenses: 85% of the retail price | Conventional contact lenses: 85% of the retail price (discount applies to materials only) | Balance after plan pays $25 discount if purchased at KP Optical | <br>85% after plan pays $100<br>Balance after plan pays $100<br>$0 |
| **Expanded Routine Vision** | *Optional Benefit*:* | *Optional Benefit*:* | | | |
| • Eyeglass frames | 80% after plan pays $100 | 80% after plan pays $100 | Not available | Not available | Not available |
| • Lenses<br>- Eyeglass lenses (standard plastic, single, bifocal or trifocal) or | $20 | $20 | Not available | Not available | Not available |
| • Contact lenses**<br>- Conventional**<br><br>- Disposable**<br>- Non-elective** | <br>85% of the retail price (discount applies to materials only)<br>Balance after plan pays $100<br>Balance after plan pays $250 | <br>85% of the retail price<br><br>Balance after plan pays $100<br>Balance after plan pays $250 | Not available | Not available | Not available |
| **Routine Hearing** | *Optional Benefit*:* | *Included in Basic Plan:* | | *Included in Basic Plan:* | *Included in Basic Plan:* |
| • Routine hearing exam (once every plan year) | $40 | $0 | Not available | $25 PCP<br>$40 Specialist | $40 |
| • Hearing aids and other hearing-aid related services | Balance after plan pays $1,200 (once every 48 months) | Not available | Not available | Not available | Balance after plan pays $1,200 (once every 48 months) |
| • Benefit maximum | $1,200 | Not available | Not available | Not available | $1,200 |
| **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 | Not available.<br>Out-of-area Dependent Children Program 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 in your Open Enrollment booklet (see premium summary).

**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.