

2023 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) Employer deposit to your HRA on July 1, 2023	Not available	\$600 employee \$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 / Two or more persons	\$1,500 / \$3,000	\$3,000 / \$6,000	\$5,000 / \$10,000	\$1,500 / \$3,000	\$1,500 / \$3,000
Doctor's visits (in person and telemedicine)					
· Primary care physician	\$25	20% after deductible	20% after deductible	\$25	Tier 1: \$5 / Tier 2: \$25
· Telehealth physician visit	\$0 Sydney Health app and livehealthonline.com	\$0 www.teladoc.com/aetna	20% after deductible Sydney Health app and www.livehealthonline.com	\$0 www.kp.org • 1-800-777-7904	\$0 MDLIVE 866-648-3638
· Specialist	\$40	20% after deductible	20% after deductible	\$40	Tier 1: \$10 / Tier 2: \$40
Hospital services					
· Inpatient / Outpatient	\$300 per stay / \$125 per visit	20% after deductible	20% after deductible	\$300 per admission / \$75 per visit	\$300 per admission / \$125 per visit
Emergency room visits	\$150 per visit (waived if admitted)	20% after deductible	20% after deductible	\$75 per visit (waived if admitted)	\$150 per visit (waived if admitted)
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	\$50 per service	Non-Emergency - 20% after deductible Emergency - \$150
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	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible	20% after deductible	\$25 PCP \$40 specialist	\$40 copay per office visit \$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/ \$40 specialist	20% after deductible	20% after deductible	\$25 per service/ \$40 specialist	PCP Tier 1: \$5 Tier 2: \$25 Specialist Tier 1: \$10 Tier 2: \$40
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) Up to 4 visits per incident	\$0	\$0	\$0	\$0	\$0
Prescription drugs – mandatory generic					
Retail Pharmacy	Up to 34-day supply \$15/\$30/\$45/\$55	20% after deductible	20% after deductible	Up to 30-day supply KP center: \$15/\$25/\$40 Specialty: 50%, \$75 max Community participating: \$20/\$45/\$60 (3x copayment for 90 days)	Up to 30-day supply \$15/\$30/\$45/\$55
Home Delivery Pharmacy	Up to 90-day supply \$30/\$60/\$90/\$110	20% after deductible	20% after deductible	\$13/\$23/\$38 (2x copayment for 90 days)	Up to 90-day supply \$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.

**30-day supply for Specialty Tier 4.

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Health Plans	COVA Care	COVA HealthAware	COVA HDHP	Kaiser Permanente	Optima Health
In-Network Benefits	You Pay	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	\$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	<i>Optional benefit*</i>	\$0	Not available	\$25 PCP/\$40 specialist	\$40
Dental Services					
· Diagnostic and preventive	\$0	\$0	\$0	\$0	\$0
Expanded Dental	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>
· 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 - Lifetime maximum benefit	50% no deductible \$2,000	50% no deductible \$2,000	50% no deductible \$2,000	50% up to \$1,000 (age 19 and under)	50% no deductible \$2,000
Routine Vision – Basic Plan	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>
· 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+) <19 \$0 (1 pair/plan year)	80% after plan pays \$100
· Eyeglass lenses - standard plastic - Single - Bifocal - Trifocal	\$50 \$70 \$105	\$40 \$60 \$80	\$50 \$70 \$105	Balance after plan pays \$75 (age 19+) <19 \$0 (1 pair/plan year)	\$20
· Contact lenses** - Conventional** - Disposable** - 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	85% after plan pays \$100 Balance after plan pays \$100 \$0
Expanded Routine Vision	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>			
· Eyeglass frames	80% after plan pays \$100	80% after plan pays \$100	Not available	Not available	Not available
· Lenses - Eyeglass lenses (standard plastic, single, bifocal or trifocal) or	\$20	\$20	Not available	Not available	Not available
· Contact lenses** - Conventional** - Disposable** - Non-elective**	85% of balance after plan pays \$100 Balance after plan pays \$100 Balance after plan pays \$250	85% of the retail price Balance after plan pays \$100 Balance after plan pays \$250	Not available	Not available	Not available
Routine Hearing	<i>Optional Benefit*:</i>	<i>Included in Basic Plan:</i>		<i>Included in Basic Plan:</i>	<i>Included in Basic Plan:</i>
· Routine hearing exam (once every plan year)	\$40	\$0	Not available	\$25 PCP / \$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	<i>Optional Benefit*:</i>	<i>Included in Basic Plan:</i>			
	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. 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.