# 2021 Benefits at a Glance

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>COVA Care</th>
<th>COVA HealthAware</th>
<th>COVA HDHP</th>
<th>Kaiser Permanente</th>
<th>Optima Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>You Receive</td>
<td>You Receive</td>
<td>You Receive</td>
<td>You Receive</td>
<td>You Receive</td>
</tr>
<tr>
<td><strong>Health Reimbursement Arrangement (HRA)</strong></td>
<td>Not available</td>
<td>$600 employee</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Employer deposit to your HRA on July 1, 2021</td>
<td>$600 enrolled spouse</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

## In-Network Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible – per plan year</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One person</td>
<td>$300</td>
<td>$1,500</td>
<td>$1,750</td>
<td>None</td>
<td>$150</td>
</tr>
<tr>
<td>• Two or more persons</td>
<td>$600</td>
<td>$3,000</td>
<td>$3,500</td>
<td>None</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Out-of-pocket expense limit – per plan year</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One person</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$5,000</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>• Two or more persons</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$10,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

## Doctor’s Visits (in person and telemedicine)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary care physician</td>
<td>$25</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$25</td>
<td>Tier 1: $5 Tier 2: $25</td>
</tr>
<tr>
<td>• Telehealth physician visit</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Specialist</td>
<td>$40</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$40</td>
<td>Tier 1: $10 Tier 2: $40</td>
</tr>
</tbody>
</table>

## Hospital Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient</td>
<td>$300 per stay</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$300 per admission</td>
<td>$300 per admission</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$125 per visit</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$75 per visit</td>
<td>$125 per visit</td>
</tr>
<tr>
<td><strong>Emergency room visits</strong></td>
<td>$150 per visit</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$75 per visit (waived if admitted)</td>
<td>$150 per visit (waived if admitted)</td>
</tr>
<tr>
<td><strong>Ambulance travel</strong></td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$50 per service</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic laboratory and x-rays</strong></td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$0 lab, pathology, shots, radiology, diagnostic tests</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Infusion services (includes IV or injected chemotherapy)</strong></td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$0 copay</td>
<td>Tier 1: $5 Tier 2: $25</td>
</tr>
</tbody>
</table>

## Outpatient therapy visits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Occupational and speech therapy</td>
<td>$25 PCP/$35 specialist</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$40 (30 visits/episode)</td>
<td>$25*</td>
</tr>
<tr>
<td>• Physical therapy only</td>
<td>$15</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$40 (30 visits/episode)</td>
<td>$25*</td>
</tr>
<tr>
<td>• Physical therapy and other related services, including manual intervention &amp; spinal manipulation</td>
<td>$25 PCP/$35 specialist</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$40 (30 visits/episode)</td>
<td>$25*</td>
</tr>
<tr>
<td>• Chiropractic services (30-visit plan year limit per member)</td>
<td>$25 PCP/$35 specialist</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$40</td>
<td>$35</td>
</tr>
<tr>
<td><strong>Autism spectrum disorder treatment and related services</strong></td>
<td>$25 per service</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$25 per visit /$40 specialist</td>
<td>Tier 1: $5 Tier 2: $25</td>
</tr>
</tbody>
</table>

## Behavioral Health

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical and non-medical professional visits</td>
<td>$25</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$12 group/$25 individual</td>
<td>$10</td>
</tr>
<tr>
<td>• Inpatient residential treatment</td>
<td>$300 per stay</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$300 per admission</td>
<td>$300 per admission</td>
</tr>
<tr>
<td>• Intensive outpatient treatment (IOP)</td>
<td>$125 per episode of care</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$12 group/$25 individual</td>
<td>$125</td>
</tr>
</tbody>
</table>

## Employee Assistance Program (EAP)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 4 visits per incident</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

## Prescription drugs – mandatory generic

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Retail Pharmacy</td>
<td>Up to 34-day supply</td>
<td>$15/$30/$45/$55</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>Up to 30-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>KP center: $15/$25/$40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Specialty 50%, $75 max</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Community participating: $20/$45/$60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3 x copayment for 90 days)</td>
</tr>
<tr>
<td>• Home Delivery Pharmacy</td>
<td>Up to 99-day supply</td>
<td>$30/$60/$90/$110</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>Up to 31-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$15/$25/$38</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2 x copayment for 90 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Up to 31-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$30/$60/$90/$110**</td>
</tr>
</tbody>
</table>

*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
<table>
<thead>
<tr>
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<th>Kaiser Permanente</th>
<th>Optima Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness &amp; Preventive Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visits at specified intervals, immunizations, lab and x-rays</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Annual Routine Vision Exam</strong></td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$25 PCP/$40 specialist</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Annual Routine Hearing Exam</strong></td>
<td>Optional benefit *</td>
<td>$0</td>
<td>Not available</td>
<td>$25 PCP/$40 specialist</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic and preventive</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Expanded Dental</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maximum benefit – per member</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$1,800</td>
<td>$2,000</td>
</tr>
<tr>
<td>• Deductible</td>
<td>$50/$100/$150</td>
<td>$50/$100/$150</td>
<td>$50/$100/$150</td>
<td>$25 per person/$75 family</td>
<td>$50/$150</td>
</tr>
<tr>
<td>• Primary (basic) care</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>• Complex restorative care (inlays, onlays, crowns, dentures, bridgework)</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>• Orthodontic</td>
<td>50% no deductible</td>
<td>50% no deductible</td>
<td>50% no deductible</td>
<td>50% up to $1,000 (age 19 and under)</td>
<td>50% no deductible</td>
</tr>
<tr>
<td><strong>Routine Vision - Basic Plan</strong></td>
<td>Included with Medical</td>
<td>Included with Medical</td>
<td>Included with Medical</td>
<td>Included with Medical</td>
<td>Included with Medical</td>
</tr>
<tr>
<td>• Annual Routine Vision Exam</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$25 PCP/$40 specialist</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Eyeglass frames</strong></td>
<td>80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses</td>
<td>65% of the retail price</td>
<td>80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses</td>
<td>Balance after plan pays $75 (age 19+) &lt;19 $0 (1 pair/plan year)</td>
<td>80% after plan pays $100</td>
</tr>
<tr>
<td><strong>Eyeglass lenses - standard plastic</strong></td>
<td>$50</td>
<td>$40</td>
<td>$50</td>
<td>Balance after plan pays $75 (age 19+) &lt;19 $0 (1 pair/plan year)</td>
<td>$20</td>
</tr>
<tr>
<td>• Single</td>
<td>$70</td>
<td>$60</td>
<td>$70</td>
<td>$60</td>
<td>$0</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$105</td>
<td>$80</td>
<td>$105</td>
<td>$80</td>
<td>$0</td>
</tr>
<tr>
<td>• Contact lenses**</td>
<td>Conventional contact lenses: 85% of the retail price (discount applies to materials only)</td>
<td>Conventional contact lenses: 85% of the retail price (discount applies to materials only)</td>
<td>Conventional contact lenses: 85% of the retail price (discount applies to materials only)</td>
<td>Balance after plan pays $25 (discount if purchased at KP Optical)</td>
<td>85% after plan pays $100</td>
</tr>
<tr>
<td>• Conventional</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>• Disposable**</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Routine Hearing</strong></td>
<td>$40</td>
<td>$0</td>
<td>Not available</td>
<td>$25 PCP/$40 specialist</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>Optional Benefit *</td>
<td>Included in Basic Plan</td>
<td>Included in Basic Plan</td>
<td>Included in Basic Plan</td>
<td>Included in Basic Plan</td>
</tr>
<tr>
<td>Plan payment reduced by 25%. Balance billing may apply</td>
<td>Additional deductible and out-of-pocket limits apply. 40% coinsurance after deductible of $3,000/$6,000. Balance billing may apply.</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available, Out-of-area Dependent Children Program available.</td>
</tr>
</tbody>
</table>

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.