2025 BENEFITS AT A GLANCE

PREMIUM AND PLAN BENEFITS MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL.

Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente HMO	Sentara Health Plans HMO
Benefits	**You Receive**	**You Receive**	**You Receive**	**You Receive**	**You Receive**
Health Reimbursement Arrangement (HRA) *Employer deposit to your HRA on July 1, 2025*	$600 employee $600 enrolled spouse	Not available	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	$1,500	$300	$1,750	None	$200
Two or more persons	$3,000	$600	$3,500	None	$400
Out-of-pocket expense limit – per plan year					
• One person / Two or more persons	$3,000 / $6,000	$1,500 / $3,000	$5,000 / $10,000	$1,500 / $3,000	$2,000 / $4,000
Doctor's visits (in person and telemedicine)					
• Primary care physician	20% after deductible	$25	20% after deductible	$25	Tier 1: $10 / Tier 2: $30
• Telehealth physician visit	$0	$0	20% after deductible	$0	$0
• Specialist	20% after deductible	$40	20% after deductible	$40	Tier 1: $20 / Tier 2: $50
• Urgent Care	20% after deductible	$25 PCP/$40 specialist	20% after deductible	$40	$60
Hospital services					
• Inpatient / Outpatient	20% after deductible	$300 per stay / $125 per visit	20% after deductible	$300 per admission / $75 per visit	$500 per admission / $200 per visit
Emergency room visits	20% after deductible	$300 per visit (waived if admitted)	20% after deductible	$75 per visit (waived if admitted)	$200 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 - $200
Outpatient diagnostic laboratory and x-rays	20% after deductible	20% after deductible	20% after deductible	$0 lab, pathology, shots, radiology, diagnostic tests	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	20% after deductible	$25 PCP/$35 specialist	20% after deductible	$40 (30 visits/episode)	$30*
• Physical therapy only	20% after deductible	$15	20% after deductible	$40 (30 visits/episode)	$30*
• Physical therapy and other related services, including manual intervention & spinal manipulation	20% after deductible	$25 PCP/$35 specialist	20% after deductible	$40 (30 visits/episode)	$30*
• Chiropractic services (30-visit plan year limit per member)	20% after deductible	$25 PCP/$35 specialist	20% after deductible	$40	$35
Autism spectrum disorder treatment and related services	20% after deductible	$25 per service/ $40 specialist	20% after deductible	$25 per service/ $40 specialist	PCP Tier 1: $10 Tier 2: $30 Specialist Tier 1: $20 Tier 2: $50
Behavioral health					
• Medical and non-medical professional visits	20% after deductible	$25	20% after deductible	$12 group/$25 individual	$10
• Inpatient residential treatment	20% after deductible	$300 per stay	20% after deductible	$300 per admission	$500 per admission
• Intensive outpatient treatment (IOP)	20% after deductible	$125 per episode of care	20% after deductible	$12 group/$25 individual	$200
Employee Assistance Program (EAP)	Up to 4 visits per incident	Up to 4 visits per incident	Up to 4 visits per incident	Up to 4 visits per incident	Up to 5 visits per incident
Prescription drugs – mandatory generic					
Retail Pharmacy	20% after deductible	Up to 34-day supply $15/$30/$45/$55	20% after deductible	Up to 30-day supply KP center: $15/$25/$40 Specialty: 50%, $75 max Community participating: $20/$45/$60 (3 x copayment for 90 days)	Up to 30-day supply $15/$30/$45/$55
Home Delivery Pharmacy	20% after deductible	Up to 90-day supply $30/$60/$90/$110	20% after deductible	$13/$23/$38 (2 x copayment for 90 days)	Up to 90-day supply $30/$60/$90/NA **

*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.
**90-day supply for Specialty Tier 4 is not available.

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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	$0	$15	$15	$25 PCP/$40 specialist	$15
Annual Routine Hearing Exam	$0	Optional benefit*	Not available	$25 PCP/$40 specialist	$40
Hearing aids and other hearing-aid related services children age 18 and younger (per hearing impaired ear)	Balance after plan pays $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)	Subject to the deductible, then 0% coinsurance. Allowance is $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)
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 - 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	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*
• Annual Routine Vision Exam	$0	$15	$15	$25 PCP/$40 specialist	$15
• Eyeglass frames	65% of the retail price	80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses	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	 $40 $60 $80	 $50 $70 $105	 $50 $70 $105	Balance after plan pays $75 (age 19+) <19 $0 (1 pair/plan year)	 $20 $20 $20
• Contact lenses** - Conventional** - Disposable** - Non-elective**	Conventional contact lenses: 85% of the retail price	Conventional contact lenses: 85% of the retail price (discount applies to materials only)	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	*Optional Benefit*:*	*Optional Benefit*:*			
• 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 the retail price Balance after plan pays $100 Balance after plan pays $250	 85% of balance after plan pays $100 Balance after plan pays $100 Covered in full	Not available	Not available	Not available
Routine Hearing	*Included in Basic Plan:*	*Optional Benefit*:*		*Included in Basic Plan:*	*Included in Basic Plan:*
• Routine hearing exam (once every plan year)	$0	$40	Not available	$25 PCP / $40 Specialist	$40
• Hearing aids and other hearing-aid related services*	Not available	Balance after plan pays $1,200 (once every 48 months)	Not available	Not available	Balance after plan pays $1,200 (once every 48 months)
• Benefit maximum	Not available	$1,200	Not available	Not available	$1,200 Adults
Out-of-Network	*Included in Basic Plan:*	*Optional Benefit*:*	*Included in Basic Plan:*		
	Additional deductible and out-of-pocket limits apply. 40% coinsurance after deductible of $3,000/$6,000. Balance billing may apply.	Plan payment reduced by 25%. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible of $1,750/$3,500. Balance billing may apply.	Not available	Not available. Out-of-area Dependent Children Program available. See plan's website for form.

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.