

## HEALTH BENEFITS AT - A - GLANCE

Benefit	COVA Care - You Pay	COVA HDHP - You Pay
<b>Deductible - per Plan Year</b>		
One Person	\$200	\$1,200
Two or More Persons	\$400	\$2,400
<b>Out-of-Pocket Expense Limit - per Plan Year</b>		
One Person	\$1,500	\$5,000
Two or More Persons	\$3,000	\$10,000
<b>Doctor's Visits</b>		
Primary Care Physician	\$25	20% coinsurance after deductible has been met.
Specialist	\$35	
<b>Hospital Services</b> (included surgery)		
	\$300 per stay	20% coinsurance after deductible has been met.
<b>Emergency Room visits</b>		
	\$100 per visit (Waived if admitted)	20% coinsurance after deductible has been met.
<b>Outpatient diagnostic laboratory, tests, shots, and x-rays</b>		
	10% Coinsurance after deductible has been met.	20% coinsurance after deductible has been met.
<b>Prescription Drugs - Mandatory Generic</b>		
Retail Pharmacy	Up to 34-day supply	
Tier One	\$15	20% coinsurance after deductible has been met.
Tier Two	\$20	
Tier Three	\$35	
Home Deliver Pharmacy (mail order service - 90 day supply)		
Tier One	\$30	20% coinsurance after deductible has been met.
Tier Two	\$40	
Tier Three	\$70	
<b>Behavioral Health and EAP</b>		
Inpatient Treatment	\$300 per stay	20% coinsurance after deductible has been met.
Outpatient Visits	\$35	20% coinsurance after deductible has been met.
EAP (up to 4 visits per incident)	\$0	\$0
<b>Wellness Services</b>		
<b>Well Child - through age 6</b>		
office visits at specified intervals, immunizations, lab and x-rays.	\$0	\$0
<b>Routine Wellness - age 7 and older</b>		
Annual checkup visit		
Primary Care Physician	\$0	\$0
Specialist	\$0	\$0
Immunizations, lab, & x-rays	\$0 (plan pays up to \$500 per member, per plan year)	\$0
* <b>Preventative Care</b> - one of each per plan year - specific age limits	\$0	\$0

\* Includes gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen test (PSA), and colorectal cancer screening.

Benefit	COVA Care - You Pay	COVA HDHP - You Pay
<b>Dental Benefit</b>		
Plan Year Deductible	\$0	\$25 each (one or two people) \$75 (family)
Plan maximum payment	Up to \$1,200 per member per plan year	Up to \$1,500 per member per plan year
Diagnostic and preventative	\$0 - Two visits per plan year	\$0 - no deductible
Primary Services	20% coinsurance	20% coinsurance after deductible
Complex Restorative	See Optional Expanded Dental	50% coinsurance after deductible
Orthodontics	See Optional Expanded Dental	50% coinsurance after deductible (\$1500 lifetime max)

### COVA Care Additional Coverage Options

Benefit	Who Pays	Administrator
<b>Out - Of - Network</b>		
May be combined with Expanded Dental or Vision, Hearing and Expanded Dental. Applies to Medical and Behavioral Health Services.	Plan payment is reduced by 25%. You pay applicable deductible, co-payment and/or coinsurance. Provider may balance bill for amount above allowable charge.	Anthem and Value Options
<b>Expanded Dental</b>		
May be combined with Out-of-Network Plan pays up to \$1,500 per member per plan year for Basic and Complex Restorative Services		Delta Dental
<b>Complex Restorative</b> (inlays, onlays, crowns, dentures, and bridgework)	You Pay - 50% coinsurance with no deductible	
<b>Orthodontics</b> - \$1,200 lifetime maximum per member	You Pay - 50% coinsurance with no deductible	
<b>Vision, Hearing and Expanded Dental</b>		
May be combined with Out-of-Network		
<b>Vision</b>		
Routine eye exam (once every 24 months)	You Pay \$35	Anthem
Eyeglass Frames (one set every 24 months)	Plan pays up to \$75	
Lenses (every 24 months)		
One pair - single vision lenses	Plan pays up to \$50	
One pair - bifocal lenses	Plan pays up to \$75	
One pair - trifocal lenses	Plan pays up to \$100	
Contact lenses - any kind	Plan pays up to \$100	
<b>Hearing</b>		
Routine hearing exam (48 mos.)	You Pay \$35	Anthem
Purchase of hearing aids and other related hearing services (\$1200 benefit max. every 48 mos.)	You Pay \$0	
<b>Expanded Dental</b>	See above	Delta Dental