COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: State Retiree Health Benefits Program Retirees, Survivors and Long Term Disability Participants who are not eligible for Medicare or who cover a family member who is not eligible for Medicare

From: Office of State and Local Health Benefits Programs

Date: April 28, 2021

Subject: ANNUAL OPEN ENROLLMENT – MAY 3—17, 2021

Your Annual Open Enrollment

Your Open Enrollment will take place from **May 3 through May 17** and provides your annual opportunity to make changes to your non-Medicare-coordinating health plan and membership level (as allowed by eligibility policy). Changes will be effective July 1, 2021. This booklet includes information about coverage options in the new plan year. Other resources to help you make your Open Enrollment decision include:

- A *2021 BENEFITS AT A GLANCE* comparison of available plan benefits (see page 11)
- A link to *ALEX*, your online benefits counselor (see page 4)

Use these resources to help you choose the plan that best meets you and your covered family members' individual needs.

This Open Enrollment period does not apply to participants in Medicare-coordinating plans (Advantage 65 and Medicare Supplemental/Option II Plans), but Medicare-eligible Retirees, Survivors and Long Term Disability Enrollees who cover non-Medicare-eligible family members receive this package so that they can make changes on behalf of their Non-Medicare covered family members.

NOTE: PREMIUMS AND PLAN BENEFITS INCLUDED IN THIS BOOKLET MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL

Monthly Premium Costs Effective July 1, 2021

The following chart includes your plan choices and monthly premiums starting July 1, 2021. If you enroll in either a COVA Care or COVA HealthAware Plan, the premiums (see shaded premiums) can be reduced by completing the requirement to earn a premium reward. More detailed information about starting or continuing premium rewards can be found on page 3.

Plans	Single	Two-Person	Family
COVA Care (with preventive dental)	**$803**	**$1,485**	**$2,154**
COVA Care + Out-of-Network	**$822**	**$1,519**	**$2,205**
COVA Care + Expanded Dental	**$837**	**$1,548**	**$2,246**
COVA Care + Out-of-Network + Expanded Dental	**$856**	**$1,582**	**$2,297**
COVA Care + Expanded Dental + Vision and Hearing	**$857**	**$1,584**	**$2,299**
COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing	**$875**	**$1,618**	**$2,349**
COVA HealthAware (with preventive dental)	**$712**	**$1,320**	**$1,909**
COVA HealthAware + Expanded Dental	**$744**	**$1,379**	**$1,995**
COVA HealthAware + Expanded Dental & Vision	**$755**	**$1,400**	**$2,025**
COVA HDHP (with preventive dental)	**$602**	**$1,120**	**$1,637**
COVA HDHP + Expanded Dental	**$635**	**$1,181**	**$1,726**
Kaiser Permanente HMO*	**$718**	**$1,320**	**$1,923**
Optima Health Vantage HMO*	**$779**	**$1,442**	**$2087**
TRICARE Supplement	**$61**	**$120**	**$161**

*Kaiser Permanente HMO and Optima Health Vantage HMO are only available to participants living in the plans' defined services areas. If you enroll in one of these plans but do not live in the service area, you will be required to change plans. Contact Kaiser or Optima directly for specific information—see *Resources* on page 9.

Some reminders if your premium is changing:

- If your premium is deducted from your VRS retirement benefit and an increase results in your VRS benefit no longer being sufficient to allow your premium deduction, direct billing will automatically begin in June for your July premium. Otherwise, your premium payments will be deducted or billed in the usual manner.
- Keep in mind that, due to administrative differences, direct billing is mailed before the coverage month, while VRS benefit deductions are taken after the coverage month. This means that you may initially be billed for a two-month premium if transition to direct billing is required.
- If you have an automatic deduction of your monthly premium billing through your financial institution or you use automatic bill pay to generate your monthly premium payment, be sure to update your account to pay your new premium amount.
- If you are receiving a health insurance credit and your premiums are not being deducted by VRS, you may need to submit a VRS-45 to report a premium change. Contact VRS for more information.

If your premium is direct billed, you will receive your monthly invoice or payment coupons from the following billing administrator:

If your plan is:	*You will be billed by:*
COVA Care	Anthem Blue Cross and Blue Shield
COVA HealthAware	PayFlex
COVA HDHP	Anthem Blue Cross and Blue Shield
Kaiser Permanente HMO	Kaiser
Optima Health Vantage HMO	Optima
TRICARE Supplement	Selman and Company

Earn Premium Rewards Again This Year!

Non-Medicare retiree group enrollees and non-Medicare-eligible covered spouses in the COVA Care or COVA HealthAware Plans are eligible to earn Premium Rewards by completing an online health assessment. Monthly premium cost in either a COVA Care Plan or a COVA HealthAware Plan will be reduced by $17 per month when the requirement is met by the enrollee, and $34 per month if the requirement is also met by the spouse.

Eligible participants must complete/update and submit their online health assessment between May 3 – 17 to earn a reward starting July 1. **If this requirement is not completed, any existing premium reward will end on June 30, 2021**. Visit your plan's website or mobile app to access your health assessment.

To earn a reward BEGINNING July 1, 2021:

COVA Care Members:

- Login at **www.anthem.com** using your credentials
- Select *My Health Dashboard* from the top navigation menu
- Select *Programs*
- Under *Programs,* select Learn more on the WebMD Health Risk Assessment card
- Click *Start your assessment, or "take it again" if you have previously completed an assessment*
- *Be sure to click on the "Finish" button for your confirmation.*

Access using the Sydney Health mobile app

- Login to the app, from the Sydney Welcome screen, click the "More" button in the bottom right corner
- Select *My Health Dashboard from the menu list*
- Scroll down and click *Featured Programs*, select *WebMD Health Assessment*
- Click *Start your assessment, or "take it again" if you have previously completed an assessment*
- Be sure to click on the "Finish" button for your confirmation.

You also may contact Anthem Blue Cross and Blue Shield at **1-800-552-2682** to complete a telephonic health assessment.

Note: As a first time user, you will need to download the *Sydney Health* mobile app from either Google Play or Apple app store. Once you have completed registration, follow the above instructions for accessing the Health Assessment.

COVA HealthAware Members:

- Login at **www.aetna.com** using your credentials
- Scroll down to "Member Resources" on the right side of the page, select "Well-being Resources" in this section to open your Member Engagement Platform.
- Once the Member Engagement Platform opens, hover over "Health" from the menu at the top and then click Health Assessment.

Access using the Aetna Health mobile app:

- Login to Aetna Health mobile app
- Select *Improve* tab
  - If accessing for the first time, select *Get Started*
  - If accessing after the first time, select *Health Survey*

To earn a reward to start AFTER July 1, 2021:

- Eligible participants can complete and submit the health assessment by the 15th of any month to start receiving the premium reward in six to eight weeks.

Follow the instructions listed above for your respective plan to submit your health assessment.

ALEX, Your Online Benefits Counselor

ALEX will again be available during Open Enrollment to assist you in comparing your health plan options. ALEX can help you decide which plan may be the most cost-effective for you. ALEX will gather information from you and, in turn, provide information to you about available plans, including an estimate of different plan costs based on your input. The final decision is yours, but ALEX is a resource to help you decide—just go to **www.myalex.com/cova/2021**.

BENEFIT CHANGES FOR JULY 1

All State Health Benefits Plans

- Member Cost Share Limit on Insulin Prescription Drug: Member cost sharing limit applied to in-network coverage for insulin prescription drugs used to treat diabetes. See chart below for member cost details.

Health Plan	At the Pharmacy, You Pay	
COVA Care	***34-day supply:*** up to $50	***90-day supply***: up to $150
COVA HDHP	***34-day supply***: 20% up to $50 after deductible is met	***90-day supply***: 20% up to $150 after deductible is met
COVA HealthAware	***34-day supply***: 20% up to $50 after deductible is met	***90-day supply***: 20% up to $150 after deductible is met
Kaiser Permanente HMO	***30-day supply***: up to $50	***90-day supply***: up to $150
Optima Health Vantage HMO	***31-day supply:*** up to $50	***90-day supply:*** up to $150

COVA Care, COVA HDHP, COVA HealthAware

- Continuous Glucose Monitors (CGM): Members will be able to purchase Continuous Glucose Monitors (CGMs) using the IngenioRx pharmacy benefit. Currently Continuous Glucose Monitors (CGM's) are only covered under the medical benefit as Durable Medical Equipment (DME). Effective with the new benefit plan year you will be able to purchase CGMs at your retail pharmacy. Note: To ensure claims are processed under the correct benefit, if you decide to purchase the CGM under the pharmacy benefit, rather than the medical benefit, you will need to obtain a new prescription from provider.

COVA Care and COVA HDHP

- LiveHealth Online Healthy Sleep: Plan members can receive new ways to treat sleep disorders. The LiveHealth Online Healthy Sleep program provides members with a home sleep evaluation in a virtual environment, where board-certified sleep specialists diagnose sleep disorders and design treatment plans to improve sleep and overall health. This program is offered at no cost for COVA Care members, and COVA HDHP members pay 20% coinsurance after the deductible is met.

Health and Wellness Programs

COVA Care, COVA HDHP and COVA HealthAware Health and Wellness Programs

- Disease Management programs provide support to help manage chronic conditions such as asthma, heart disease, diabetes, chronic obstructive pulmonary disease (COPD) coronary artery disease and hypertension. These programs are administered by the medical plan claims administrator. Contact your health plan (see *Resources* on page 9).

COVA Care and COVA HealthAware Incentive Programs

- Participants in these plans can receive certain medications or supplies at no cost to treat the following conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes and high blood pressure. Medication compliance and quarterly health coaching are required. Contact your health plan (see *Resources* on page 9).

- Enrolled members have access to a nurse coach and other maternity support specially designed to help make good choices throughout the pregnancy and to help you have a safe delivery and a healthy child. Enrollment within the first 16 weeks of pregnancy and participation with a nurse coach can result in waiver of the hospital copayment or a $300 contribution to your Health Reimbursement Arrangement (HRA), depending on your plan.

- Plan participants have access to a weight management coach who will provide one-on-one goal oriented support for weight management and nutrition counseling as well as personalized coaching and disease management. You are required to participate in your plan's 12-month weight management coaching and education program. Contact your health plan (see *Resources* on page 9).

You may also find information on similar programs for Kaiser Permanente and Optima Health Vantage HMO on their respective websites.

Making Open Enrollment Changes

If you wish to make a plan or membership change during Open Enrollment, you must complete a *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants*. The forms are available online in a fillable format on the DHRM website at **www.dhrm.virginia.gov**, or complete the enrollment form enclosed in your open enrollment packet.

Completing the form:

- Indicate *"Open Enrollment"* as the reason for your change.
- Sign the completed form. **The Enrollment form must be signed by the eligible Enrollee.** This is either the Retiree, Survivor, or Long Term Disability participant through whom eligibility for coverage is obtained—***not a covered family member***. Even those covered family members who have separate/individual ID numbers must have their Enrollment Forms signed by the Enrollee. Enrollment Forms will not be accepted if not signed by the Enrollee.
- Follow the mailing instructions on the form to submit your changes to your Benefits Administrator.
- Forms must be postmarked no later than May 17, 2021, to be accepted.

If you make a plan change, be sure that you understand the provisions of the plan that you choose. **After the Open Enrollment period ends, you may not revise your Open Enrollment election because you changed your mind or you completed the form incorrectly.**

If you are requesting a membership increase, you must include documentation to support eligibility for the new family member. For example:

- To add an existing spouse, you must provide photocopies of the marriage certificate and the top portion of the first page of the retiree group enrollee's most recent Federal Tax Return that confirms the spouse (all financial information and Social Security Numbers should be removed).
- To add a biological or adopted child, you must include a photocopy of the birth certificate showing the retiree group Enrollee's or spouse's name as the parent or a photocopy of a legal pre-adoptive or adoptive agreement.

For other eligible membership additions, contact your Benefits Administrator to confirm the necessary documentation. Supporting documentation must be received by the end of the Open Enrollment period. If it is not received, your membership increase will not be processed.

Making Changes After Open Enrollment - After the Open Enrollment period, membership ***increases*** will only be allowed based on the occurrence of a consistent qualifying mid-year event (such as marriage or birth of a child). Membership increases must be accompanied by appropriate documentation to support the addition (see above). **Enrollees have 60 days from the event to make a change based on a qualifying mid-year event.** Retiree group Enrollees may ***decrease*** membership prospectively (going forward) at any time

Retiree Group News and Reminders...

Member Handbooks –Plan Member handbooks are posted on the DHRM website at **www.dhrm.virginia.gov/employeebenefits/health-benefits**. Be sure to review your plan's member handbook and associated amendments for more details on your plan. If you are enrolled in a regional plan, please visit your plan's website for the Evidence of Coverage (EOC).

IMPORTANT!! When You Become Eligible for Medicare – When Retiree Group Enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered family members become eligible for Medicare, Medicare becomes the primary health plan, and they must make a decision as to whether they wish to maintain secondary coverage under the State Retiree Health Benefits Program or terminate that coverage. In most cases, Medicare-eligible participants will be contacted through the Enrollee and provided with their options approximately three months in advance of their Medicare eligibility date due to age. If no positive election is made, they will be automatically moved to the Advantage 65 with Dental/Vision Plan, a Medicare supplemental plan that includes Medicare Part D prescription drug coverage (contingent upon approval by Medicare), dental and vision. Even though the state program makes every effort to identify participants who become eligible for Medicare, it is the responsibility of the Enrollee to ensure that any participants who become eligible for Medicare are moved to Medicare-coordinating coverage immediately upon Medicare eligibility. Failure to move to Medicare-coordinating coverage immediately upon eligibility for Medicare can result in retraction of primary payments made in error and a gap in coverage. The state program will not make primary claim payments when Medicare should be the primary coverage. Contact your Benefits Administrator if you need additional information (see page 9).

Some important things to consider when making this coverage decision:

- If you wish to select your Medicare-coordinating plan through the state program, you must enroll in Medicare Parts A and B (Original Medicare) in order to get the full benefit of the Advantage 65 Plans, the state program's Medicare supplemental coverage. Failure to enroll in Medicare Parts A and B can result in a significant deficit in your coverage since Advantage 65 will not pay claims that Medicare would have paid had you been enrolled.
- As a Medicare-eligible participant, you may select from available Advantage 65 Plans.
- If an Enrollee requests termination of coverage in the State Retiree Health Benefits Program, he or she may not re-enroll. Termination of the Enrollee will result in termination of all covered family members. For more information about *Medicare and the State Retiree Health Benefits Program*, go to **www.dhrm.virginia.gov** and look for *Retiree Fact Sheets*.

Prompt Payment of Premiums - Enrollees are responsible for timely payment of their monthly premiums (either through VRS retirement benefit deduction or by direct payment to the billing administrator). Participants who pay directly receive monthly bills or coupons which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Claims paid during any period for which premium payment is not received will be recovered. Once an Enrollee and/or his/her covered family members have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except at the sole discretion of the Department of Human Resource Management.

Enrollees are responsible for understanding the amount of their premium and for notifying their Benefits Administrator within 60 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Address Changes – **Was this package forwarded to you from an old address?** If so, be sure to contact your Benefits Administrator immediately to make an address correction, including an updated telephone number. If you have an email address, you may ask to have it included in your eligibility record. Failure to update your mailing address can result in missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss, including billing statements, because their address of record is incorrect. The Department's only means of reaching many retiree group participants is through the US Postal Service. Please let your Benefits Administrator know when you move!

If You Need Help… Retiree group participants should contact their Benefits Administrator with enrollment and eligibility questions. Benefits Administrators are generally unable to assist with claim or coverage problems, and those questions should be directed to your claims administrator. Please see *Resources* on page 9 for contact information.

Enclosures:

- **Summary of Benefits and Coverage for your current plan**
- **Important Notices Summary**
- **CHIP Notice**
- **Balance Billing Notice**
- **State Health Benefits Enrollment Form for Retirees, Survivors and LTD Participants**

If you have questions about eligibility and enrollment, contact your Benefits Administrator:

If You Are A:	***Contact This Benefits Administrator***
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 **www.varetire.org**
Local or Optional Retirement Plan Retiree	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (a survivor of an employee or retiree, not receiving a VRS benefit)	Department of Human Resource Management 888-642-4414 **www.dhrm.virginia.gov**

The Department of Human Resource Management web site has more information about the State Retiree Health Benefits Program. Go to www.dhrm.virginia.gov

RESOURCES

Plan	Benefit	Contact Information
COVA Care and **COVA HDHP**	• Medical, Vision & Hearing (Anthem BCBS) • Behavioral Health Benefits & EAP (Anthem) • Dental (Delta Dental of Virginia) • Prescription Drug (Anthem Pharmacy)	• 800-552-2682 **www.anthem.com/cova** • 855-223-9277 **www.anthemEAP.com** **Company Code: Commonwealth of Virginia** • 888-335-8296 **www.deltadentalva.com** • 833-267-3108 **www.anthem.com**
COVA HealthAware	• Medical, Vision, Hearing and Behavioral Health (Aetna) • Employee Assistance Program (EAP) (Aetna) • Prescription Drug (Anthem Pharmacy) • Dental (Delta Dental) • Teladoc Virtual Visits	• 855-414-1901 **www.covahealthaware.com** • 888-238-6232 **www.mylifevalues.com** (Username & Password: COVA) • 833-267-3108 **www.anthem.com** • 888-335-8296 **www.deltadentalva.com** • **www.teladoc.com/aetna**
Kaiser Permanente HMO	• Medical, Prescription Drug and Vision (Kaiser) • Dental (Dominion National) • EAP (Beacon Health Options) • Behavioral Health (Kaiser)	• 800-777-7902; 301-468-6000 in Washington, D.C. **https://my.kp.org/commonwealthofvirginia/** • 855-733-7524 **http://www.DominionNational.com/kaiser** • 866-517-7042 **www.achievesolutions.net/kaiser** • 866-530-8778
Optima Health Vantage HMO	• Medical, Prescription Drug, Dental, Vision, Behavioral Health • Employee Assistance Program (EAP)	• 866-846-2682 **www.optimahealth.com/cova or members@optimahealth.com** • **https://login.optimaeap.com (Username: Cova)**
TRICARE Supplement	Selman and Company (SelmanCo)	• 800-638-2610 (press option 1)

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) **Employer deposit to your HRA on July 1, 2021**	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	$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 Tier 2: $25
• Telehealth physician visit	$0 www.livehealthonline.com	$0 www.teladoc.com/aetna	20% after deductible 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	$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 (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	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 $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	20% after deductible	20% after deductible	$25 per visit /$40 specialist	Tier 1: $5 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) 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 (3 x copayment for 90 days)	Up to 31-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 (2 x 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.
**31-day supply for Specialty Tier 4

2021 BENEFITS AT A GLANCE

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	*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 – 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	$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	*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 (discount applies to materials only) 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	*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 $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. 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.