CoventryOne

Carelink Individual Plans Off-Exchange

Monroe High Performance Network:
1st Tier: St. Francis Medical Center
2nd Tier: Glenwood Regional, EA Conway Medical, Monroe Surgical and Ouachita Community

PLAN BENEFITS	Carelink Gold $0 Copay HMO		Carelink Silver $10 Copay HMO		Carelink Bronze $10 Copay HMO	
	In-Network St. Francis	2nd Tier network	In-Network St. Francis	2nd Tier network	In-Network St. Francis	2nd Tier network
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Annual Deductible (per calendar year Individual/family)	$1,250 $2,500	$3,750 $7,500	$3,750 $7,500	$6,000 $12,000	$5,500 $11,000	$6,000 $12,000
Coinsurance	20%	40%	30%	40%	30%	40%
Out-of-Pocket Maximum* (per calendar year, per Individual/Family)	$5,000 $10,000	$6,000 $12,000	$6,350 $12,700	$6,350 $12,700	$6,350 $12,700	$6,350 $12,700
Medical benefits shown with Copays are not subject to Deductibles unless specified	**In-Network St. Francis**	**2nd Tier network**	**In-Network St. Francis**	**2nd Tier network**	**In-Network St. Francis**	**2nd Tier network**
Primary Physician Office Visit (PCP required)	$0	$25 Copay	$10 Copay	$50 Copay + Ded	$15 Copay	$50 Copay + Ded
Specialist Office Visit (PCP referral required)	First 5 Visits: $50 6+ Visits: $50 Copay + Ded	$75 Copay + Ded	First 2 Visits: $75; 3+ Visits: $75 Copay + Ded	$75 Copay + Ded	First Visit: $75; 2+ Visits: $75 Copay + Ded	$100 Copay + Ded
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	$0	$0	$0	$0
Lab/Radiology* **	Incl in PCP office visit; Spec/Outpt: Ded/Coins	Ded/Coins	Incl in PCP office visit; Spec/Outpt: Ded/Coins	Ded/Coins	Included in PCP office visit; Specialist/Outpatient: Ded/Coins	Ded/Coins
Advanced Imaging/High Tech Radiology	PCP/Spec/Outpt: Ded/ Coins Free-standing Facility: $250 Copay	PCP/Spec: Ded/Coins; Outpatient: $100 Copay + Ded/Coins	PCP/Spec/Outpt:$250 Copay + Ded/Coins; Free- standing Facility:$250 + Ded	PCP/Spec/Outpt:$500 Copay + Ded/Coins; Free- standing Facility: Ded + Coins	PCP/Spec/Outpt:$250 Copay + Ded/Coins; Free- standing Facility:$250 + Ded	PCP/Spec/Outpt:$500 Copay + Ded/Coins; Free- standing Facility: Ded + Coins
Urgent Care	$75 Copay	$150 Copay	$75 Copay	Ded/Coins	$150 Copay	$150 Copay + Ded.
Emergency Care	First 3 Visits: $250 Copay 4+ Visits: $250 Copay + Ded	$250 Copay + Ded	First Visit: $500 Copay; 2+ Visits: $500 Copay+ Ded.	$750 Copay + Ded/Coins	First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded	$750 Copay + Ded/Coins
Inpatient Hospitalization (physician and surgical services)	Ded/Coins	$250 Copay + Ded/Coins	$500 Copay + Ded/Coins	$1,000 Copay + Ded/Coins	$500 Copay + Ded/Coins	$1,000 Copay + Ded/Coins
Outpatient Facility and Physician Services/Home Health Care/ Hospice/Skilled Nursing Facility	Ded/Coins		Ded/Coins		Ded/Coins; Home Health/ Hospice: Ded/20% Coins	Ded/Coins; Home Health/ Hospice: Ded/20% Coins
Rehabilitation Services (Physical, Speech, Occupational, Respiratory) *Up to 25 visits for all therapies combined*	Ded/Coins		Ded/Coins		Ded/Coins	
Maternity and Newborn Care	Prenatal office visits: $0 Copay; Physician charges: $250 Copay; Inpatient: Ded/Coins	Prenatal office visits: $500 one-time Copay; Physician charges: $0; Inpatient: $250 Copay + Ded/Coins	Prenatal office visits: $0; Physician charges: One-time $250 Copay; Inpatient: $500 Copay + Ded/Coins	Prenatal office visits: Ded/Coins; Physician charges: Ded; Inpatient: $1,000 Copay + Ded/Coins	Prenatal office visits: $0; Physician charges: One-time $500 Copay; Inpatient: $500 Copay + Ded/Coins	Prenatal office visits/ Physician charges: Ded; Inpatient: $1,000 Copay + Ded/Coins
Mental Health Office Visit/Outpatient/Inpatient** (Outpt/Inpt)	First 5 office visits: $50; 6+visits: $50 Copay + Ded; Outpatient/Inpatient: Ded/Coins	Office visit: $75 Copay + Ded; Outpatient: Ded/Coins; Inpatient: $250 Copay+ Ded/Coins	Office visit: First 2 Visits: $75; 3+ Visits: $75 Copay + Ded.; Outpatient: Ded/Coins; Inpatient: $500 Copay + Ded/Coins	Office visit: $75 Copay + Ded; Outpt: Ded/Coins; Inpatient: $1,000 Copay + Ded/Coins	Office: First Visit: $75; 2+ Visits: $75 + Ded.; Outpatient/Inpatient: $500Copay + Ded/Coins	Office/Outpt: Ded/Coins.; Inpatient: $1,000 Copay + Ded/Coins
Pediatric Vision	One routine eye examination per year. One pair of standard eyeglass lenses or contact lenses per year; one frame per year.		One routine eye examination per year. One pair of standard eyeglass lenses or contact lenses per year; one frame per year.		One routine eye examination per year. One pair of standard eyeglass lenses or contact lenses per year; one frame per year.	
Pediatric Dental	One check-up every 6 months; Preventive & Diagnostic 100%: exams, cleanings, x-rays; Basic 50%: fillings, anesthesia, general services; Major 50%: crowns, dentures, bridges, oral surgery, orthodontia		One check-up every 6 months; Preventive & Diagnostic 100%: exams, cleanings, x-rays; Basic 50%: fillings, anesthesia, general services; Major 50%: crowns, dentures, bridges, oral surgery, orthodontia		One check-up every 6 months; Preventive & Diagnostic 100%: exams, cleanings, x-rays; Basic 50%: fillings, anesthesia, general services; Major 50%: crowns, dentures, bridges, oral surgery, orthodontia	
Pharmacy	**No Rx Ded**		**Separate $1000 Rx Ded Tiers 2-5**		**Integrated Medical/Rx Ded**	
- **Tier 1A:** Lower Cost Preferred Generic Drugs	Retail pharmacy: $3, Mail order: $6		Retail pharmacy: $5, Mail order: $10		N/A	
- **Tier 1:** Preferred Generic Drugs	Retail pharmacy: $5, Mail order: $10		Retail pharmacy: $15, Mail order: $30		Retail pharmacy: $15, Mail order: $30	
- **Tier 2:** Preferred Brand Drugs	Retail pharmacy: $30, Mail order: $75		Retail pharmacy: Ded + $45, Mail order: Ded + $112.50		Retail pharmacy: Ded + $45, Mail order: Ded + $112.50	
- **Tier 3:** Nonpreferred Brand/Generic Drugs	Retail pharmacy: $55, Mail order: $165		Retail pharmacy: Ded + $75, Mail order: Ded + $225		Retail pharmacy: Ded + $75, Mail order: Ded + $225	
- **Tier 4:** Preferred Specialty Drugs	Retail pharmacy: 20% Coinsurance		Retail pharmacy: Ded + 30% Coinsurance		Retail pharmacy: Ded + 30% Coinsurance	
- **Tier 5:** Nonpreferred Specialty Drugs	Retail pharmacy: 30% Coinsurance		Retail pharmacy: Ded + 40% Coinsurance		Retail pharmacy: Ded + 40% Coinsurance	

Note: *The out-of-pocket maximum includes Deductible, Copays, Coinsurance. **When more than one person is applying for coverage, the Family Deductible and out-of-pocket maximum must be met before any benefits are paid that are subject to the Deductible or out-of-pocket maximum. ***Lab work drawn at PCP but processed by outside vendor, will not be included in Copay. ****MHNET Providers only.