



Summary of Health Plans

North Carolina

Effective July 1, 2012

CoventryOne is a health insurance product in North Carolina and South Carolina underwritten and administered by Coventry Health Care of the Carolinas, Inc. This information is a partial description of the benefits and in no way details all of the benefits, limitations or exclusions of the plan. Please refer to the Certificate of Insurance and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.



TRADITIONAL COPAY PLANS - Coventry Health Care of the Carolinas, Inc.

In-Network Benefits	Plan 3A	Plan 5A	Plan 6A	Plan 7A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>				
Maximum Lifetime Benefit (per member)	Unlimited			
Deductible (per member or three times per family)	\$1,000	\$500	\$1,000	\$2,500
Coinsurance (Plan pays in-network)	100%	80% after Deductible		
Coinsurance Maximum (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum)	Not Applicable	\$2,000		
Physician Office Visit (PCP) General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$15 Copay			
Specialty Physician Office Services Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$30 Copay			
Preventive Services Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	Coventry pays 100%			
Urgent Care Facility Services	\$30 Copay			
Emergency Room Services (waived if admitted to the hospital)	\$250 Copay			
Inpatient and Outpatient Hospital Services Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	Coventry pays 100% after Deductible	Coventry pays 80% after Deductible		
Vision Exam (every 12 months)	\$15 Copay for in-network routine vision exam			
Chiropractic Services (20 visits per benefit year)	\$15 Copay			
Prescription Drug Coverage	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>			
Prescription Deductible	Not Applicable			
Tier 1: Preferred Generic	\$10			
Tier 2: Formulary Brand	\$35			
Tier 3: Non-Formulary	\$50			
Tier 4: Self-Administered Injectable Drugs and some Specialty Medications	10%			
Out-of-Network Benefits	Plan 3A	Plan 5A	Plan 6A	Plan 7A
Deductible (per member, maximum three times per family)	\$2,000	\$1,000	\$2,000	\$5,000
Coinsurance	Coventry pays 70% after Deductible			
Coinsurance Maximum (per member, maximum two times in-network)	Not Applicable	\$4,000		
Physician Office Services, Inpatient and Outpatient Hospital Services	Coventry pays 70% after Deductible			
<p><i>This summary is only a partial description of coverage and does not detail all benefits, limitations and exclusions. The complete terms of coverage are contained in the official coverage documents which are the certificate of coverage, the schedule of payments and any applicable riders, amendments, supplemental benefits or endorsements. In the event of any differences between this brochure and the official coverage documents, the coverage documents will control. All plans are subject to a 12 month period for pre-existing conditions except when a condition is disclosed at the time of medical underwriting or if the individual is under 19 years of age. Please note that routine maternity, mental health and substance abuse, vision hardware, infertility and sexual dysfunction are items excluded from this product.</i></p>				



VALUE COPAY PLANS – Coventry Health Care of the Carolinas, Inc.

In-Network Benefits	Plan 9A	Plan 10A	Plan 11A	Plan 12A	Plan 14A	Plan 16A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>						
Maximum Lifetime Benefit (per member)	Unlimited					
Deductible (per member or three times per family)	\$1,000	\$2,500	\$3,500	\$5,000	\$2,500	\$5,000
Coinsurance (Plan pays in-network)	Coventry pays 70% after Deductible			50% after Deductible		
Coinsurance Maximum (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum)	\$3,000					
Physician Office Visit (PCP) General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$25 Copay			\$30 Copay		
Specialty Physician Office Services Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$50 Copay			\$60 Copay		
Preventive Services Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	Coventry pays 100%					
Urgent Care Facility Services	\$50 Copay			\$60 Copay		
Emergency Room Services (waived if admitted to the hospital)	\$250 Copay		Coventry pays 70% after Deductible	\$250 Copay	Coventry pays 50% after Deductible	
Inpatient and Outpatient Hospital Services Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	Coventry pays 70% after Deductible			Coventry pays 50% after Deductible		
Vision Exam (every 12 months)	\$25 Copay for in-network routine vision exam			\$30 Copay		
Chiropractic Services (20 visits per benefit year)	\$25 Copay			\$30 Copay		
Prescription Drug Coverage	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>					
Prescription Deductible (applies to all Tiers)	\$200			\$500		
Tier 1: Preferred Generic	\$10					
Tier 2: Formulary Brand	\$35					
Tier 3: Non-Formulary	\$50					
Tier 4: Self-Administered Injectable Drugs and some Specialty Medications	10%					
Out-of-Network Benefits	Plan 9A	Plan 10A	Plan 11A	Plan 12A	Plan 14A	Plan 16A
Deductible (per member, maximum three times per family)	\$2,000	\$5,000	\$7,000	\$10,000	\$5,000	\$10,000
Coinsurance	Coventry pays 60% after Deductible			Coventry pays 40% after Deductible		
Coinsurance Maximum (per member, maximum two times in-network)	\$6,000					
Physician Office Services, Inpatient and Outpatient Hospital Services	Coventry pays 70% after Deductible			Coventry pays 40% after Deductible		

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EXTRA VALUE COPAY PLANS – Coventry Health Care of the Carolinas, Inc.

In-Network Benefits	Plan 20A	Plan 21A	Plan 23A	Plan 25A	Plan 27A	Plan 29A	Plan 31A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>							
Maximum Lifetime Benefit (per member)	Unlimited						
Deductible (per member or three times per family)	\$1,500	\$2,500	\$5,000	\$2,500	\$5,000	\$2,500	\$5,000
Coinsurance (Plan pays in-network)	Coventry pays 70% after Deductible						
Coinsurance Maximum (in-network after deductible, per benefit year, maximum two times the individual coinsurance maximum)	\$3,000						
Physician Office Visit (PCP) General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Simple Labs and X-rays (when performed in office).	\$25 Copay		\$30 Copay		\$40 Copay		
Specialty Physician Office Services Includes Simple Labs and X-rays (when performed in office), Allergy Testing and Treatments	\$50 Copay		\$60 Copay		\$80 Copay		
Preventive Services Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	Coventry pays 100%						
Urgent Care Facility Services	\$50 Copay		\$60 Copay		\$80 Copay		
Emergency Room Services (waived if admitted to the hospital)	\$500 Copay						
Inpatient and Outpatient Hospital Services Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	Coventry pays 70% after Deductible						
Vision Exam (every 12 months)	\$25 Copay		\$30 Copay		\$40 Copay		
Chiropractic Services (20 visits per benefit year)	\$25 Copay		\$30 Copay		\$40 Copay		
Prescription Drug Coverage A	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90 day supply.</i>						
Prescription Deductible	\$200 applies to Tiers 2, 3, 4		\$500 applies to Tiers 2, 3, 4		\$1,000 applies to Tiers 2, 3, 4		
Tier 1: Preferred Generic	\$10						
Tier 2: Formulary Brand	\$35		\$50		\$70		
Tier 3: Non-Formulary	\$50		\$75		\$100		
Tier 4: Self-Administered Injectable Drugs and some Specialty Medications	10%						
Out-of-Network Benefits	Plan 20A	Plan 21A	Plan 23A	Plan 25A	Plan 27A	Plan 29A	Plan 31A
Deductible (per member, maximum three times per family)	\$3,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000
Coinsurance	Coventry pays 60% after Deductible						
Coinsurance Maximum (per member, maximum two times in-network)	\$6,000						
Physician Office Services, Inpatient and Outpatient Hospital Services	Coventry pays 60% after Deductible						

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QHDHP PLANS – Coventry Health Care of the Carolinas, Inc.

In-Network Benefits	QHDHP 7A	QHDHP 10A	QHDHP 13A	QHDHP 16A	QHDHP 19A
<i>Benefit year deductible must be satisfied before coinsurance applies. Benefits listed with a copay are not subject to deductible unless noted.</i>					
Maximum Lifetime Benefit (per member)	Unlimited				
Deductible (per member)	\$2,000	\$2,700	\$3,000	\$4,000	\$5,000
Family Deductible (per family)	\$4,000	\$5,450	\$6,000	\$8,000	\$10,000
Coinsurance (Plan pays in-network)	WellPath pays 100% after Deductible				
Maximum Out-of-Pocket (in-network after deductible, per benefit year, maximum two per family)	\$2,000	\$2,700	\$3,000	\$4,000	\$5,000
Physician Office Visit (PCP) General Physician, Family Practitioner, Pediatrician or Internist; Includes Office Visits, Labs & X-rays (when performed in office).	Coventry pays 100% after Deductible				
Specialty Physician Office Services Includes Labs and X-rays (when performed in office), Allergy Testing and Treatments	Coventry pays 100% after Deductible				
Preventive Services Includes Pap Smears, Mammograms, PSA Testing, Colorectal Cancer Screening, Routine Child/Adult Well-Care Exams and immunizations.	Coventry pays 100%				
Urgent Care Facility Services	Coventry pays 100% after Deductible				
Emergency Room Services (waived if admitted to the hospital)	Coventry pays 100% after Deductible				
Inpatient and Outpatient Hospital Services Includes X-ray, Lab, Diagnostic Services, MRI, CT and PET scans, Other Nuclear Med, Surgery, Anesthesia, Chemotherapy, Radiation Treatment	Coventry pays 100% after Deductible				
Prescription Drug Coverage	<i>Retail must be obtained from participating pharmacies (except in an emergency). Mail order is a 90-day supply.</i>				
Prescription Deductible	Not Applicable				
Tier 1: Preferred Generic	Coventry pays 100% after Deductible				
Tier 2: Formulary Brand	Coventry pays 100% after Deductible				
Tier 3: Non-Formulary	Coventry pays 100% after Deductible				
Tier 4: Self-Administered Injectable Drugs and some Specialty Medications	Coventry pays 100% after Deductible				
Out-of-Network Benefits	QHDHP 7A	QHDHP 10A	QHDHP 13A	QHDHP 16A	QHDHP 19A
Deductible (per member)	\$4,000	\$5,450	\$6,000	\$8,000	\$10,000
Family Deductible (per family)	\$8,000	\$10,900	\$12,000	\$16,000	\$20,000
Coinsurance	Coventry pays 70% after Deductible				
Maximum Out-of-Pocket (per member)	\$5,250	\$6,650	\$7,250	\$9,250	\$11,250
Maximum Out-of-Pocket (per family)	\$10,500	\$13,400	\$12,150	\$17,250	\$22,200
Physician Office Services, Inpatient and Outpatient Hospital Services	Coventry pays 70% after Deductible				

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Coventry Health Care of the Carolinas, Inc. CoventryOneSM Summary of Limitations and Exclusions



Limitations and Exclusions

It is important for you to understand that certain medical services are not covered by Coventry Health Care of the Carolinas, Inc. ("CHC-Carolinas"). A summary is provided here. **This represents a partial list. See your Certificate of Coverage for a complete list. Many of the terms contained in this summary are defined in the official Coverage documents mentioned above.**

The following services, supplies and devices are not covered::

- Routine maternity care, elective abortions and routine pre- and post-natal care
- Mental health or chemical dependency treatment
- Diagnosis, care, and treatment for infertility or sexual dysfunction
- Artificial insemination
- Donation, preservation and storage of sperm, eggs, or embryos
- Surrogate parenting
- Drug treatments for stimulating ovulation
- In-vitro fertilization
- Donor costs, including sperm for artificial insemination
- Reversal of voluntary sterilization
- Penile or testicular prosthesis
- Cosmetic procedures and resulting complications except for reconstructive breast surgery following a mastectomy and certain corrections of congenital defects
- Custodial care (inpatient or outpatient)
- Long-term physical therapy and rehabilitation
- Long-term speech therapy,
- Hearing and educational, and psychological testing and therapy, including hearing aids for members over age 21 and cochlear implants
- Some organ and tissue transplants and some donor expenses when the donee is covered by CHC-Carolinas
- Mechanical organ replacement devices
- Televisions, telephones, guest beds, and other items for your comfort or convenience
- Private room accommodations, unless medically necessary
- Special duty nursing
- Experimental or investigational treatments
- Pharmacy services and prescription drugs (unless covered by a Rider)
- Growth hormones except to treat a congenital anomaly such as Turner's Syndrome
- Disposable or consumable outpatient supplies (except for diabetic supplies)
- External prosthetic devices, other than those specified as covered
- Cranial molding helmets
- Durable medical equipment, other than that specified as covered
- Transportation, except for an ambulance in a medical emergency or when approved by CHC-Carolinas
- Treatments and evaluations required by employers, insurers, schools, camps, courts, licensing authorities and other third parties
- Treatment for certain work-related injuries or illnesses paid under North Carolina Worker's Compensation laws.
- Acupuncture, naturopathy, sleep therapy and hypnotherapy
- Routine foot care
- Food and food supplements and services related to weight gain or loss
- Gastric bypass surgery
- Dental care and oral surgical services
- Eyeglasses and contact lenses, except for the first pair of eyeglasses or contacts prescribed as a result of cataract surgery
- Radial keratotomy, keratoplasty and similar surgeries or procedures for the correction of eyesight
- Sex-change surgery
- Care rendered by a relative
- Cost in excess of the Out-of-Network Rate
- Hair transplants
- Immunizations for work or travel
- Respite care
- Cognitive therapy

- Orthodontia and related services
- Care and treatment for which you have no legal obligation to pay
- Non-Emergency services related to a noncovered service and non-emergency services in an emergency facility
- Charges for missed appointments and Physician telephone consultations
- Costs for medical records for claims payment, prior approval or appeals
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- War or acts of war
- Treatment of mental retardation or developmental delay

To be covered, services must be medically necessary, specifically included by the Coverage documents, and obtained in accordance with Coventry Health Care of the Carolinas, Inc. guidelines and procedures, including any requirement to obtain prior approval of coverage from Coventry Health Care of the Carolinas, Inc.

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