



Individual Plans off the Exchange

PLAN BENEFITS	Gold \$5 Copay Plan You Pay		Silver \$10 Copay Plan You Pay		Bronze \$10 Copay Plan You Pay		Bronze Deductible Only HSA Eligible Plan You Pay		Catastrophic 100% Plan You Pay	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Annual Deductible (per calendar year, Individual/Family)	\$1,750 Individual	\$3,500 Family	\$3,750 Individual	\$7,500 Family	\$5,600 Individual	\$11,200 Family	\$6,300 Individual	\$12,600 Family	\$6,350 Individual**	\$12,700 Family**
Coinsurance	20%		30%		30%		0%		0%	
Out-of-Pocket Maximum* (per calendar year, Individual/Family)	\$5,000 Individual	\$10,000 Family	\$6,350 Individual	\$12,700 Family	\$6,350 Individual	\$12,700 Family	\$6,300 Individual	\$12,600 Family	\$6,350 Individual**	\$12,700 Family**
Medical benefits shown with Copays are not subject to Deductibles unless specified										
Primary Physician Office Visit (PCP)	\$5 Copay		\$10 Copay		\$10 Copay		Deductible		First 3 visits: \$20 Copay; 4+ visits: Deductible	
Specialist Office Visit	First 5 visits: \$50; 6+ visits \$50 Copay + Deductible		First visit: \$75; 2+ visits \$75 Copay + Deductible		\$75 Copay + Deductible		Deductible		Deductible	
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	\$0		\$0		\$0		\$0		\$0	
Lab/Radiology***	Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance		Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance		Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance		Deductible		Deductible	
Advanced Imaging/HighTech Radiology	PCP/Specialist/Outpatient: Deductible/Coinsurance; Free-standing Facility: \$250 Copay		PCP/Specialist/Outpatient: \$250 Copay + Deductible/Coinsurance; Free-standing Facility: \$250 Copay + Deductible		PCP/Specialist/Outpatient: \$250 Copay + Deductible/Coinsurance; Free-standing Facility: \$250 Copay + Deductible		Deductible		Deductible	
Convenience Care	\$25 Copay		\$25 Copay		\$25 Copay		Deductible		Deductible	
Urgent Care	\$75 Copay		\$75 Copay		\$75 Copay + Deductible		Deductible		Deductible	
Emergency Care	First 3 visits: \$250 Copay; 4+ visits: \$250 Copay + Deductible		First visit: \$500 Copay; 2+ visits: \$500 Copay + Deductible		\$500 Copay + Deductible		Deductible		Deductible	
Inpatient Hospitalization (Physician and surgical services)	Deductible/Coinsurance		\$500 Copay + Deductible/Coinsurance		\$500 Copay + Deductible/Coinsurance		Deductible		Deductible	
Outpatient Facility and Physician Services/Home Health Care/Hospice/Skilled Nursing Facility	Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance		Deductible		Deductible	
Rehabilitation Services (Physical, Speech, Occupational, Respiratory). Up to 30 visits for all therapies combined	Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance		Deductible		Deductible	
Maternity and Newborn Care	Prenatal office visits: \$0 Copay; Physician: \$250 one-time Copay; Inpatient: Deductible/Coinsurance		Prenatal office visits: \$0 Copay; Physician: \$250 one-time Copay; Inpatient: \$500 Copay + Deductible/Coinsurance		Prenatal office visits: \$0 Copay; Physician: \$500 one-time Copay; Inpatient: \$500 Copay + Deductible/Coinsurance		Prenatal office visits: \$0 Copay; Physician/Inpatient: Deductible		Prenatal office visits: \$0 Copay; Physician/Inpatient: Deductible	
Mental Health Office Visit/Outpatient/Inpatient****	First 5 office visits: \$50 Copay; 6+ visits: \$50 Copay + Deductible; Outpatient/Inpatient: Deductible/Coinsurance		First office visit: \$75 Copay; 2+ visits: \$75 Copay + Deductible; Outpatient: Deductible/Coinsurance; Inpatient: \$500 Copay + Deductible/Coinsurance		Office visit: \$75 Copay + Deductible; Outpatient: Deductible/Coinsurance; Inpatient: \$500 Copay + Deductible/Coinsurance		Deductible		Deductible	
Pediatric Vision	One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.		One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.		One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.		One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.		One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.	
Pediatric Dental	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance		Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance		Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance		Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance		Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance	
Pharmacy	Rate \$250 Single/\$500 Family Rx Deductible on Tiers 2-5		Separate \$1000 Single/\$2000 Family Rx Deductible on Tiers 2-5		Integrated Medical/RX Deductible Tiers 2-5		Integrated Medical/Rx Deductible		Integrated Medical/Rx Deductible	
- Tier 1A: Lower Cost Preferred Generic Drugs	No Deductible; Preferred pharmacy \$3; Non-preferred pharmacy \$10; Mail order \$6		No Deductible; Preferred pharmacy \$5; Non-preferred pharmacy \$20; Mail order: \$10		N/A		N/A		N/A	
- Tier 1: Preferred Generic Drugs	No Deductible; Preferred pharmacy \$5; Non-preferred pharmacy \$10; Mail order \$10		No Deductible; Preferred pharmacy \$15; Non-preferred pharmacy \$20; Mail order \$30		Preferred Pharmacy \$15; Non-preferred pharmacy \$20; Mail order \$30		Deductible		Deductible	
- Tier 2: Preferred Brand Drugs	Preferred pharmacy Deductible + \$30; Non-preferred pharmacy: Deductible + \$40; Mail order Deductible + \$75		Preferred pharmacy: Deductible + \$45; Non-preferred pharmacy: Deductible + \$55; Mail order: Deductible + \$112.50		Preferred pharmacy: Deductible + \$45; Non-preferred pharmacy: Deductible + \$55; Mail order: Deductible + \$112.50		Deductible		Deductible	
- Tier 3: Non-preferred Brand/Generic Drugs	Preferred pharmacy: Deductible + \$60; Non-preferred pharmacy: Deductible + \$75; Mail order: Deductible + \$180		Preferred pharmacy: Deductible + \$75; Non-preferred pharmacy: Deductible + \$85; Mail order: Deductible + \$225		Preferred pharmacy: Deductible + \$75; Non-preferred pharmacy Deductible + \$85; Mail order: Deductible + \$225		Deductible		Deductible	
- Tier 4: Preferred Specialty Drugs	Pharmacy Deductible + 20% Coinsurance		Preferred pharmacy: Deductible + 30% Coinsurance		Preferred pharmacy: Deductible + 30% Coinsurance		Deductible		Deductible	
- Tier 5: Non-preferred Specialty Drugs	Pharmacy Deductible + 30% Coinsurance		Preferred pharmacy: Deductible + 40% Coinsurance		Preferred pharmacy: Deductible + 40% Coinsurance		Deductible		Deductible	

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. The following individuals are eligible for catastrophic plans On-Exchange: individuals who have not attained the age of 30 prior to the first day of the contract year or individuals who have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of PPACA. Pediatric vision and dental benefits are only available for children who are under the age of 19 on Jan. 1st of the calendar year. CoventryOne is a health insurance product underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care. 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 Individual Policy, Schedule of Payments, and