

Bronze CoventryOne Health Plan options in West Missouri

Coventry is a Qualified Health Plan issuer in the Missouri Health Insurance Exchange.

Plan	W-MO Coventry Bronze Deductible Only HSA Eligible PPO	
	In network	Out of network
Member benefits		
Deductible (ded) individual family¹ (applies to out-of-pocket maximum)	\$6,300/\$12,600	\$12,600/\$25,200
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$6,300/\$12,600	\$14,000/\$28,000
Primary care visit	Covered in full after ded	50% after ded
Specialist visit	Covered in full after ded	50% after ded
Hospital stay	Covered in full after ded	50% after ded
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded	50% after ded
Emergency room (copay waived if admitted)	Covered in full after ded	Covered in full after ded
Urgent care	Covered in full after ded	50% after ded
Preventive care (age and frequency limits apply)	Covered in full; ded waived	50% after ded
Diagnostic lab	Covered in full after ded	50% after ded
Diagnostic X-ray	Covered in full after ded	50% after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded	50% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	50% after ded
Pediatric dental		
Dental checkup/preventive dental care	Not covered	Not covered
Basic dental care	Not covered	Not covered
Pharmacy*		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	P=Covered in full after ded; NP=Covered in full after ded	50% after ded
Preferred brand drugs	P=Covered in full after ded; NP=Covered in full after ded	50% after ded
Nonpreferred drugs**	P=Covered in full after ded; NP=Covered in full after ded	50% after ded
Specialty drugs***	P=Covered in full after ded; NP=Covered in full after ded	50% after ded

*P=Preferred in-network pharmacy; NP=Nonpreferred in-network pharmacy.

**Includes nonpreferred generic and brand drugs.

***P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

¹The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limit are separate in and out of network.

²Any applicable benefit maximums are combined in and out of network.

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Bronze CoventryOne Health Plan options in West Missouri

(Continued)

W-MO Coventry Bronze \$20 Copay PPO

In network	Out of network
\$5,750/\$11,500	\$11,500/\$23,000
0%	50%
\$6,600/\$13,200	\$12,500/\$25,000
\$20 copay; ded waived	50% after ded
\$50 copay after ded	50% after ded
\$250 copay per admission after ded	50% after ded
\$250 copay after ded	50% after ded
\$250 copay after ded	\$250 copay after ded
\$60 copay after ded	50% after ded
Covered in full; ded waived	50% after ded
Covered in full after ded	50% after ded
\$100 copay after ded	50% after ded
\$250 copay after ded	50% after ded
Covered in full; ded waived	50% after ded
Not covered	Not covered
Not covered	Not covered
Integrated with medical ded	Integrated with medical ded
P: \$15 copay; ded waived; NP: \$20 copay; ded waived	50% after ded
P: \$45 copay after ded; NP: \$55 copay after ded	50% after ded
P: \$75 copay after ded; NP: \$85 copay after ded	50% after ded
P: 40% after ded; NP: 50% after ded	50% after ded

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Silver CoventryOne Health Plan options in West Missouri

Coventry is a Qualified Health Plan issuer in the Missouri Health Insurance Exchange.

Plan	W-MO Coventry Silver HSA Eligible PPO	
Member benefits	In network	Out of network
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$2,600/\$5,200	\$5,200/\$10,400
Member coinsurance	10%	40%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$4,850/\$9,700	\$16,350/\$32,700
Primary care visit	10% after ded	40% after ded
Specialist visit	10% after ded	40% after ded
Hospital stay	10% after ded	40% after ded
Outpatient surgery (ambulatory surgical center/hospital)	10% after ded	40% after ded
Emergency room	10% after ded	10% after ded
Urgent care	10% after ded	40% after ded
Preventive care (age and frequency limits apply)	Covered in full; ded waived	40% after ded
Diagnostic lab	10% after ded	40% after ded
Diagnostic X-ray	10% after ded	40% after ded
Imaging (CT/PET scans, MRIs)	10% after ded	40% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	50% after ded
Pediatric dental		
Dental checkup/preventive dental care	Not covered	Not covered
Basic dental care	Not covered	Not covered
Pharmacy*		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs**	P: T1A-\$3 copay after ded/ T1-\$10 copay after ded; NP: T1A-\$10 copay after ded/ T1-\$15 copay after ded	50% after ded
Preferred brand drugs	P: \$40 copay after ded; NP: \$50 copay after ded	50% after ded
Nonpreferred drugs***	P: \$70 copay after ded; NP: \$80 copay after ded	50% after ded
Specialty drugs[†]	P: 40% after ded; NP: 50% after ded	50% after ded

*P=Preferred in-network pharmacy; NP=Nonpreferred in-network pharmacy.

**T1A=Value drugs; T1=Preferred generic drugs.

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Silver CoventryOne Health Plan options in West Missouri

(Continued)

W-MO Coventry Silver \$10 Copay PPO

In network	Out of network
\$3,750/\$7,500	\$7,500/\$15,000
30%	50%
\$6,600/\$13,200	\$16,000/\$32,000
\$10 copay; ded waived	50% after ded
Visit 1–2: \$75 copay, ded waived Visits 3+: \$75 copay after ded	50% after ded
\$500 copay per admission and ded then 30%	50% after ded
\$250 copay after ded; then 30%	50% after ded
Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded	Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded
\$75 copay; ded waived	50% after ded
Covered in full; ded waived	50% after ded
30% after ded	50% after ded
30% after ded	50% after ded
\$250 copay after ded; then 30%	50% after ded
Covered in full; ded waived	50% after ded
Not covered	Not covered
Not covered	Not covered
\$500 per member	\$1,000 per member
P: T1A-\$5 copay; ded waived/ T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived	50% after ded
P: \$45 copay after ded; NP: \$55 copay after ded	50% after ded
P: \$75 copay after ded; NP: \$85 copay after ded	50% after ded
P: 40% after ded; NP: 50% after ded	50% after ded

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¹The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit. Deductible and/or out-of-pocket limit are separate in and out of network.

²Any applicable benefit maximums are combined in and out of network.

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Silver CoventryOne Health Plan options in West Missouri

Coventry is a Qualified Health Plan issuer in the Missouri Health Insurance Exchange.

Plan	W-MO Coventry Silver \$5 Copay 2750 PPO	
Member benefits	In network	Out of network
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$2,750/\$5,500	\$7,000/\$14,000
Member coinsurance	40%	50%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$6,600/\$13,200	\$12,000/\$24,000
Primary care visit	\$5 copay; ded waived	50% after ded
Specialist visit	Visit 1 – 2: \$75 copay, ded waived Visits 3+: \$75 copay after ded	50% after ded
Hospital stay	40% after ded	50% after ded
Outpatient surgery (ambulatory surgical center/hospital)	40% after ded	50% after ded
Emergency room	Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded	Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded
Urgent care	\$75 copay; ded waived	50% after ded
Preventive care (age and frequency limits apply)	Covered in full; ded waived	50% after ded
Diagnostic lab	40% after ded	50% after ded
Diagnostic X-ray	40% after ded	50% after ded
Imaging (CT/PET scans, MRIs)	40% after ded	50% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	50% after ded
Pediatric dental		
Dental checkup/preventive dental care	Not covered	Not covered
Basic dental care	Not covered	Not covered
Pharmacy*		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs**	P: T1A-\$3 copay; ded waived/ T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived	50% after ded
Preferred brand drugs	P: \$40 copay after ded; NP: \$50 copay after ded	50% after ded
Nonpreferred drugs***	P: \$70 copay after ded; NP: \$80 copay after ded	50% after ded
Specialty drugs[†]	P: 40% after ded; NP: 50% after ded	50% after ded

*P=Preferred in-network pharmacy; NP=Nonpreferred in-network pharmacy.

**T1A=Value drugs; T1=Preferred generic drugs.

***Includes nonpreferred generic and brand drugs.

[†]P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

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Gold CoventryOne Health Plan option in West Missouri

Coventry is a Qualified Health Plan issuer in the Missouri Health Insurance Exchange.

Plan	W-MO Coventry Gold \$5 Copay PPO	
Member benefits	In network	Out of network
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$600/\$1,200	\$2,500/\$5,000
Member coinsurance	25%	50%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$6,500/\$13,000	\$17,000/\$34,000
Primary care visit	\$5 copay; ded waived	50% after ded
Specialist visit	Visit 1 – 5: \$50 copay, ded waived Visits 6+: \$50 copay after ded	50% after ded
Hospital stay	25% after ded	50% after ded
Outpatient surgery (ambulatory surgical center/hospital)	25% after ded	50% after ded
Emergency room (copay waived if admitted)	Visit 1 – 3: \$250 copay, ded waived Visits 4+: \$250 copay after ded	Visit 1 – 3: \$250 copay, ded waived Visits 4+: \$250 copay after ded
Urgent care	\$75 copay; ded waived	50% after ded
Preventive care (age and frequency limits apply)	Covered in full; ded waived	50% after ded
Diagnostic lab	25% after ded	50% after ded
Diagnostic X-ray	25% after ded	50% after ded
Imaging (CT/PET scans, MRIs)	25% after ded	50% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	50% after ded
Pediatric dental		
Dental checkup/preventive dental care	Not covered	Not covered
Basic dental care	Not covered	Not covered
Pharmacy*		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs**	P: T1A-\$3 copay; ded waived/ T1-\$10 copay; ded waived; NP: T1A-\$15 copay; ded waived/ T1-\$15 copay; ded waived	50% after ded
Preferred brand drugs	P: \$35 copay after ded; NP: \$45 copay after ded	50% after ded
Nonpreferred drugs***	P: \$65 copay after ded; NP: \$80 copay after ded	50% after ded
Specialty drugs[†]	P: 30% after ded; NP: 50% after ded	50% after ded

*P=Preferred in-network pharmacy; NP=Nonpreferred in-network pharmacy.

**T1A=Value drugs; T1=Preferred generic drugs.

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