CoventryOne®

NC Individual Off Exchange Plans

Carelink-Duke Medicine Network

PLAN BENEFITS	Gold $0 Copay			Silver $10 Copay		
	Tier 1 Duke Medicine	Tier 2 CHC Carolinas POS Network	Tier 3 Out-of-Network	Tier 1 Duke Medicine	Tier 2 CHC Carolinas POS Network	Tier 3 Out-of-Network
Lifetime Maximum	Unlimited			Unlimited		
Annual Deductible (per calendar year Individual/family)	$1,250 $2,500	$3,750 $7,500	$6,400 $12,800	$3,750 $7,500	$6,000 $12,000	$6,400 $12,800
Coinsurance	20%	40%	50%	30%	40%	50%
Out-of-Pocket Maximum* (per calendar year, per Individual/Family)	$5,000 $10,000	$6,000 $12,000	Unlimited	$6,350 $12,700	$6,350 $12,700	Unlimited
	Member cost share accumulates to the Deductible and Out-of Pocket Maximum for both Tier 1 and 2.					
Medical benefits shown with Copays are not subject to Deductibles unless specified	**Tier 1 You Pay**	**Tier 2 You Pay**	**Tier 3 You Pay**	**Tier 1 You Pay**	**Tier 2 You Pay**	**Tier 3 You Pay**
Primary Physician Office Visit (PCP)	$0	$25 Copay	Ded/30%	$10 Copay	$50 Copay + Ded	Ded/30%
Specialist Office Visit (Spec)	First 5 Visits: $50; 6+ Visits: $50 Copay + Ded	$75 Copay + Ded	Ded/30%	First 2 Visits: $75; 3+ Visits: $75 Copay + Ded	$75 Copay + Ded	Ded/30%
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	Ded/30%	$0	$0	Ded/30%
Lab/Radiology* **	Incl in PCP office visit; Spec/Outpt: Ded/Coins	PCP office visit: Ded/30%; Spec/Outpt: Ded/Coins	Ded/Coins	Incl in PCP office visit; Spec/Outpt: Ded/Coins	PCP office visit: Ded/30%; Spec/Outpt: Ded/Coins	Ded/Coins
Advanced Imaging/High Tech Radiology	PCP/Spec/Outpt: Ded/ Coins; Free-standing Facility: $250 Copay	PCP/Spec: Ded/Coins; Outpt: $100 Copay + Ded/Coins; Free-standing Facility: Ded/30%	PCP/Spec/Free-standing Facility: Ded/Coins; Outpt:$250 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:$500 Copay + Ded/Coins; Free- standing Facility: Ded + Coins
Convenience Care	$25 Copay	$50 Copay	Ded/30%	$25 Copay	Ded/30%	Ded/Coins
Urgent Care	$75 Copay	$150 Copay	Ded/30%	$75 Copay	Ded/30%	Ded/Coins
Emergency Care	First 3 Visits: $250 Copay; 4+ Visits: $250 Copay + Ded	$250 Copay + Ded	$250 Copay + Ded	First Visit: $500 Copay; 2+ Visits: $500 Copay+ Ded.	$750 Copay + Ded/Coins	$750 Copay + Ded/30% Coins.
Inpatient Hospitalization (physician and surgical services)	Ded/Coins	$250 Admit + Ded/Coins	$1,000 Admit + Ded/Coins	$500 Admit + Ded/Coins	$1,000 Admit + Ded/Coins	$1,000 Admit + Ded/Coins
Outpatient Facility and Physician Services/Home Health Care/Hospice/Skilled Nursing Facility	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Rehabilitation Services -- Physical, Occupational, Chiropractic up to 30 visits for all therapies combined -- Speech separate 30 visit limit	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Maternity and Newborn Care	Prenatal office visits: $0 Copay; Physician charges: $250 Copay; Inpt: Ded/Coins	Prenatal office visit/Physician charges: $0; Inpt: $250 Admit + Ded/Coins	Prenatal office visits: Ded/30%; Physician charges: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins	Prenatal office visits: $0; Physician charges: One-time $250 Copay; Inpt: $500 Admit + Ded/Coins	Prenatal office visits: $0; Physician charges: Ded/30%; Inpt: $1,000 Admit + Ded/Coins	Prenatal office visits: Ded/30%; Physician charges: Ded./Coins: Inpt: $1,000 Admit + Ded/Coins
Mental Health Office Visit/Outpatient/Inpatient** (Outpt/Inpt)	First 5 office visits: $50; 6+visits: $50 Copay + Ded; Outpt/Inpt: Ded/Coins	Office visit: $75 Copay + Ded; Outpt: Ded/Coins; Inpt: $250 Admit+ Ded/Coins	Office visit: Ded/30%; Outpt: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins	Office visit: First 2 Visits: $75; 3+ Visits: $75 Copay + Ded.; Outpt: Ded/Coins; Inpt: $500 Admit + Ded/Coins	Office visit: $75 Copay + Ded; Outpt: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins	Office visit: Ded/30%; Outpt: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins
Pediatric Vision (members under age 19)	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 (members under age 19)	Diagnostic and Preventive: $0; Restorative Basic/Major: Deductible + 50%			Diagnostic and Preventive: $0; Restorative Basic/Major: Deductible + 50%		
Pharmacy	**No Rx Ded**			**Separate $1000 Rx Ded Tiers 2-5**		
- **Tier 1A:** Lower Cost Preferred Generic Drugs	$3 Copay/Mail order $6 Copay			$5 Copay/Mail order $10 Copay		
- **Tier 1:** Preferred Generic Drugs	$5 Copay/Mail order $10			$15 Copay/Mail order $30 Copay		
- **Tier 2:** Preferred Brand Drugs	$30Copay/Mail order $75 Copay			Ded + $45 Copay//Mail order Ded + $112.50 Copay		
- **Tier 3:** Nonpreferred Brand/Generic Drugs	$55 Copay/ Mail order $165 Copay			Ded + $75 Copay/Mail order Ded + $225 Copay		
- **Tier 4:** Preferred Specialty Drugs	20% Coinsurance			Ded + 30% Coinsurance		
- **Tier 5:** Nonpreferred Specialty Drugs	30% Coinsurance			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. ****Magellan Behavioral Health 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.

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NC Individual Off Exchange Plans

Carelink-Duke Medicine Network

PLAN BENEFITS	Bronze $15 Copay			Bronze 100% HSA Eligible		Catastrophic	
	Tier 1 Duke Medicine	Tier 2 CHC Carolinas POS Network	Tier 3 Out-of-Network	In-Network Duke Medicine	Out-of-Network	In-Network Duke Medicine	Out-of-Network
Lifetime Maximum	Unlimited			Unlimited		Unlimited	
Annual Deductible (per calendar year Individual/family)	$5,500 $11,000	$6,000 $12,000	$6,400 $12,800	$6,300 Individual $12,600 Family	Not Covered	$6,350 Individual** $12,700 Family**	Not Covered
Coinsurance	30%	40%	50%	0%	Not Covered	0%	Not Covered
Out-of-Pocket Maximum* (per calendar year, per Individual/Family)	$6,350 $12,700	$6,350 $12,700	Unlimited	$6,300 Individual $12,600 Family	Not Covered	$6,350 Individual** $12,700 Family**	Not Covered
	Member cost share accumulates to the Deductible and Out-of Pocket Maximum for both Tier 1 and 2.						
Medical benefits shown with Copays are not subject to Deductibles unless specified	Tier 1 You Pay	Tier 2 You Pay	Tier 3 You Pay	In Network You Pay	Out-of-Network You Pay	In Network You Pay	Out-of-Network You Pay
Primary Physician Office Visit (PCP)	$15 Copay	$50 Copay + Ded	Ded/30%	Ded	Not Covered	First 3 visits: $20 Copay; 4+ visits: Ded	Not Covered
Specialist Office Visit (Spec)	First Visit: $75; 2+ Visits: $75 Copay + Ded	$100 Copay + Ded	Ded/30%	Ded	Not Covered	Ded	Not Covered
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	Ded/30%	$0	Not Covered	$0	Not Covered
Lab/Radiology* **	Incl in PCP office visit; Spec/Outpt: Ded/Coins	PCP office visit: Ded/30%; Spec/Outpt: Ded/Coins	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Advanced Imaging/High Tech Radiology	PCP/Spec/Outpt:$250 Copay + Ded/Coins; Free- standing Facility:$250 + Ded	PCP/Spec/Outpt:$500 Copay + Ded/Coins; Free- standing Facility: Ded/30%	PCP/Spec/Outpt:$500 Copay + Ded/Coins; Free- standing Facility: Ded + Coins	Ded	Not Covered	Ded	Not Covered
Convenience Care	$25 Copay	Ded/30%	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Urgent Care	$150 Copay	$150 Copay + Ded.	Ded/30%	Ded	Not Covered	Ded	Not Covered
Emergency Care	First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded	$750 Copay + Ded/Coins	$750 Copay + Ded/40% Coins.	Ded		Ded	
Inpatient Hospitalization (physician and surgical services)	$500 Admit + Ded/Coins	$1,000 Admit + Ded/Coins	$1,000 Admit + Ded/Coins	Ded	Not Covered	Ded	Not Covered
Outpatient Facility and Physician Services/Home Health Care/Hospice/Skilled Nursing Facility	Ded/Coins; Home Health/ Hospice: Ded/20% Coins	Ded/Coins; Home Health/ Hospice: Ded/20% Coins	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Rehabilitation Services -- Physical, Occupational, Chiropractic up to 30 visits for all therapies combined -- Speech separate 30 visit limit	Ded/Coins	Ded/Coins	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Maternity and Newborn Care	Prenatal office visits: $0; Physician charges: One-time $500 Copay; Inpt: $500 Admit + Ded/Coins	Prenatal office visits $0/ Physician charges: Ded/30%; Inpt: $1,000 Admit + Ded/Coins	Prenatal office Visits/Physician charges: Ded/Coins; Inpt: $1,000 Admit+ Ded/Coins	Prenatal office visits $0 Copay: Physician/inpt service: Ded	Not Covered	Prenatal office visits $0 Copay: Physician/inpt service: Ded	Not Covered
Mental Health Office Visit/Outpatient/Inpatient** (Outpt/Inpt)	Office: First Visit: $75; 2+ Visits: $75 + Ded.; Outpt Ded/Coins/Inpt: $500 Admit + Ded/Coins	Office Ded/ $100 Copay/Outpt: Ded/Coins.; Inpt: $1,000 Admit + Ded/Coins	Office visit: Ded/30%; Outpt: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins	Ded	Not Covered	Ded	Not Covered
Pediatric Vision (members under age 19)	One routine eye examination per year. One pair of standard eyeglass lenses or contact lenses per year; one frame per year.			One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.	Not Covered	One pair of eyeglasses with frame or contact lenses per year; one routine eye exam.	Not Covered
Pediatric Dental (members under age 19)	Diagnostic and Preventive: $0; Restorative Basic/Major: Deductible + 50%			Diagnostic and Preventive: $0; Restorative Basic/Major: Deductible + 50%	Not Covered	Diagnostic and Preventive: Deductible; Restorative Basic/Major: Deductible + 50%	Not Covered
Pharmacy	Integrated Medical/Rx Ded			Integrated Medical/Rx Ded		Integrated Medical/Rx Ded	
- **Tier 1A:** Lower Cost Preferred Generic Drugs	N/A			N/A		N/A	
- **Tier 1:** Preferred Generic Drugs	$15 Copay/Mail order $30 Copay			Ded		Ded	
- **Tier 2:** Preferred Brand Drugs	Ded + $45 Copa/Mail order Ded + $112.50			Ded		Ded	
- **Tier 3:** Nonpreferred Brand/Generic Drugs	Ded + $75 Copay/Mail order Ded + $225 Copay			Ded		Ded	
- **Tier 4:** Preferred Specialty Drugs	Ded + 30% Coinsurance			Ded		Ded	
- **Tier 5:** Nonpreferred Specialty Drugs	Ded + 40% Coinsurance			Ded		Ded	