CoventryOne

Individual Plans on the Exchange

Effective: January 1, 2014

Oklahoma
PPO Plans

PLAN BENEFITS	Gold $5 Copay Plan		Silver $10 Copay Plan		Bronze $10 Copay Plan		Bronze Deductible Only HSA Eligible Plan		Catastrophic Plan	
	In-Network PPO	Out-of-Network You Pay	In-Network PPO	Out-of-Network You Pay	In-Network PPO	Out-of-Network You Pay	In-Network PPO	Out-of-Network You Pay	In-Network PPO	Out-of-Network You Pay
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Annual Deductible (per calendar year Individual/family)	$1,750 Individual $3,500 Family	$6,400 Individual $12,800 Family	$3,750 Individual $7,500 Family	$6,400 Individual $12,800 Family	$5,600 Individual $11,200 Family	$6,400 Individual $12,800 Family	$6,300 Individual $12,600 Family	$6,400 Individual $12,800 Family	$6,350 Individual** $12,700 Family**	$6,400 Individual** $12,800 Family**
Coinsurance	20%	50%	30%	50%	30%	50%	0%	50%	0%	50%
Out-of-Pocket Maximum* (per calendar year, per Individual/Family)	$5,000 Individual $10,000 Family	Unlimited	$6,350 Individual $12,700 Family	Unlimited	$6,350 Individual $12,700 Family	Unlimited	$6,300 Individual $12,600 Family	Unlimited	$6,350 Individual** $12,700 Family**	Unlimited
Medical benefits shown with Copays are not subject to Deductibles unless specified	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network	Out-of-Network You Pay	In-Network	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Primary Physician Office Visit (PCP)	$5 Copay	Deductible/Coinsurance	$10 Copay	Deductible/Coinsurance	$10 Copay	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	First 3 visits: $20 Copay; 4+ visits: Deductible	Deductible/Coinsurance
Specialist Office Visit	First 5 visits: $50; 6+ visits $50 Copay + Deductible	Deductible/Coinsurance	First visit: $75; 2+ visits $75 Copay + Deductible	Deductible/Coinsurance	$75 Copay + Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	Deductible/Coinsurance	$0	Deductible/Coinsurance	$0	Deductible/Coinsurance	$0	Deductible/Coinsurance	$0	Deductible/Coinsurance
Lab/Radiology* **	Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance	Deductible/Coinsurance	Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance	Deductible/Coinsurance	Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Advanced Imaging/High Tech Radiology	PCP/Specialist/Outpatient: Deductible/Coinsurance; Free-standing Facility: $250 Copay	PCP/Specialist/Free-standing Facility: Deductible/ Coinsurance; Outpatient: $250 Copay+ Deductible/Coinsurance	PCP/Specialist/Outpatient: $250 Copay + Deductible/Coinsurance; Free-standing Facility:$250 Copay + Deductible	PCP/Specialist/Outpatient: $250 Copay + Deductible/ Coinsurance; Free-standing Facility: Deductible/Coinsurance	PCP/Specialist/Outpatient: $250 Copay + Deductible/ Coinsurance; Free-standing Facility:$250 Copay + Deductible	PCP/Specialist/Outpatient: $250 Copay + Deductible/ Coinsurance; Free-standing Facility: Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Convenience Care	$25 Copay	Deductible/Coinsurance	$25 Copay	Deductible/Coinsurance	$25 Copay	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Urgent Care	$75 Copay	Deductible/Coinsurance	$75 Copay	Deductible/Coinsurance	$75 Copay + Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Emergency Care	First 3 visits: $250 Copay; 4+ visits: $250 Copay + Deductible	First 3 visits: $250 Copay; 4+ visits: $250 Copay + Deductible	First visit: $500 Copay; 2+ visits: $500 Copay + Deductible	First visit: $500 Copay; 2+ visits: $500 Copay + Deductible	$500 Copay + Deductible	$500 Copay + Deductible	Deductible	Deductible	Deductible	Deductible
Inpatient Hospitalization (physician and surgical services)	Deductible/Coinsurance	$1,000 Copay + Deductible/Coinsurance	$500 Copay + Deductible/Coinsurance	$1,000 Copay + Deductible/Coinsurance	$500 Copay + Deductible/Coinsurance	$1,000 Copay + Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Outpatient Facility and Physician Services/Home Health Care/Hospice/Skilled Nursing Facility	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Rehabilitation Services (Physical, Speech, Occupational, Respiratory) *Up to 25 visits for all therapies combined*	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
Maternity and Newborn Care	Prenatal office visits: $0 Copay; Physician charges: $250 one-time Copay; Inpatient: Deductible/Coinsurance	Prenatal office visits/physician charges: Deductible/ Coinsurance; Inpatient: $1,000 Copay + Deductible/ Coinsurance	Prenatal office visits: $0 Copay; Physician charges: $250 one-time Copay, Inpatient: $500 Copay + Deductible/Coinsurance	Prenatal office visits/physician charges: Deductible/ Coinsurance; Inpatient: $1,000 Copay + Deductible/Coinsurance	Prenatal office visits: $0 Copay; Physician charges: $500 one-time Copay; Inpatient: $500 Copay + Deductible/ Coinsurance	Prenatal office visits/physician charges: Deductible/ Coinsurance; Inpatient: $1,000 Copay + Deductible/ Coinsurance	Prenatal office visits: $0 Copay; physician charges/Inpatient: Deductible	Deductible/Coinsurance	Prenatal office visits $0 Copay; Physician charges/Inpatient: Deductible	Deductible/Coinsurance
Mental Health Office Visit/Outpatient/Inpatient****	First 5 office visits: $50 Copay; 6+ visits: $50 Copay + Deductible; Outpatient/ Inpatient: Deductible/ Coinsurance	Office visit/Outpatient: Deductible/Coinsurance; Inpatient: $1,000 Copay + Deductible/Coinsurance	First office visit: $75 Copay; 2+ visits: $75 Copay + Deductible; Outpatient: Deductible/ Coinsurance; Inpatient: $500 Copay + Deductible/Coinsurance	Office visit/Outpatient: Deductible/Coinsurance; Inpatient: $1,000 Copay + Deductible/Coinsurance	Office visit: $75 Copay + Deductible; Outpatient: Deductible/Coinsurance; Inpatient: $500 Copay + Deductible/Coinsurance	Office visit/Outpatient: Deductible/Coinsurance; Inpatient: $1,000 Copay + Deductible/Coinsurance	Deductible	Deductible/Coinsurance	Deductible	Deductible/Coinsurance
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.	
Pharmacy	Separate $250 Deductible on Tiers 2-5		Separate $1,000 Deductible on Tiers 2-5		Integrated Medical/Rx Deductible		Integrated Medical/Rx Deductible		Integrated Medical/Rx Deductible	
- **Tier 1A:** Lower Cost Preferred Generic Drugs	No Deductible. Preferred pharmacy: $3; Nonpreferred Pharmacy $10; Mail order: $6		No Deductible. Preferred pharmacy: $5; Nonpreferred pharmacy: $20; Mail order: $10		N/A		N/A		N/A	
- **Tier 1:** Preferred Generic Drugs	No Deductible. Preferred pharmacy: $5; Nonpreferred pharmacy: $10; Mail order: $10		No Deductible. Preferred pharmacy: $15; Nonpreferred pharmacy: $20; Mail order: $30		No Deductible. Preferred pharmacy: $15; Nonpreferred pharmacy: $20; Mail order: $30		Deductible		Deductible	
- **Tier 2:** Preferred Brand Drugs	Preferred pharmacy: Deductible + $30; Nonpreferred pharmacy: Deductible + $40; Mail order: Deductible +$75		Preferred pharmacy: Deductible + $45; Nonpreferred pharmacy: Deductible + $55; Mail order: Deductible + $112.50		Preferred pharmacy: Deductible + $45; Nonpreferred pharmacy: Deductible + $55; Mail order: Deductible + $112.50		Deductible		Deductible	
- **Tier 3:** Nonpreferred Brand/Generic Drugs	Preferred pharmacy: Deductible + $60; Nonpreferred pharmacy: Deductible + $75; Mail order: Deductible + $180		Preferred pharmacy: Deductible + $75; Nonpreferred pharmacy: Deductible + $85; Mail order: Deductible + $225		Preferred pharmacy: Deductible + $75; Nonpreferred pharmacy: Deductible + $85; Mail order: Deductible + $225		Deductible		Deductible	
- **Tier 4:** Preferred Specialty Drugs	Preferred pharmacy Deductible + 20% Coinsurance		Preferred pharmacy Deductible + 30% Coinsurance		Preferred pharmacy Deductible + 30% Coinsurance		Deductible		Deductible	
- **Tier 5:** Nonpreferred Specialty Drugs	Preferred 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. *****This benefit is only available for children who are under the age of 19 on January 1st of the calendar year.