CoventryOne®

SC Individual Exchange Plans

Carelink-Roper St. Francis Network

PLAN BENEFITS	Gold $0 Copay			Silver $10 Copay		
	Tier 1 Roper St. Francis	Tier 2 CHC Carolinas POS Network	Tier 3 Out-of-Network	Tier 1 Roper St. Francis	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/Coins	$10 Copay	$50 Copay + Ded	Ded/Coins
Specialist Office Visit (Spec) *referral from PCP required*	First 5 Visits: $50; 6+ Visits: $50 Copay + Ded	$75 Copay + Ded	Ded/Coins	First 2 Visits: $75; 3+ Visits: $75 Copay + Ded	$75 Copay + Ded	Ded/Coins
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	Ded/Coins	$0	$0	Ded/Coins
Lab/Radiology*	Incl in PCP office visit; Spec/Outpt: Ded/Coins	Ded/Coins	Ded/Coins	Incl in PCP office visit; Spec/Outpt: Ded/Coins	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	PCP/Spec: 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/Coins	$25 Copay	Ded/Coins	Ded/Coins
Urgent Care	$75 Copay	$150 Copay	Ded/Coins	$75 Copay	Ded/Coins	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/ 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, Speech) *Physical Therapy limited to 30 days*	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 visits: $500 one-time Copay; Physician charges: $0; Inpt: $250 Admit + Ded/Coins	Prenatal office visits/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: Ded; Physician charges: Ded; Inpt: $1,000 Admit + Ded/Coins	Prenatal office visits/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/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: Ded/Coinc; Outpt: Ded/Coins; Inpt: $1,000 Admit + Ded/Coins	Office visit/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.		
Pharmacy	**No Rx Ded**			**Separate $1000 Rx Ded Tiers 2-5**		
- **Tier 1A:** Lower Cost Preferred Generic Drugs	Preferred pharmacy $3/Nonpreferred pharmacy $10/Mail order $6			Preferred pharmacy $5/Nonpreferred pharmacy $20/Mail order $10		
- **Tier 1:** Preferred Generic Drugs	Preferred pharmacy $5/Nonpreferred pharmacy $10/Mail order $10			Preferred pharmacy $15/Nonpreferred pharmacy $20/Mail order $30		
- **Tier 2:** Preferred Brand Drugs	Preferred pharmacy $30/ Nonpreferred pharmacy $40/Mail order $75			Preferred pharmacy Ded + $45/Nonpreferred pharmacy Ded + $55/Mail order Ded + $112.50		
- **Tier 3:** Nonpreferred Brand/Generic Drugs	Preferred pharmacy: $55/ Nonpreferred pharmacy $65/ Mail order $165			Preferred pharmacy Ded + $75/ Nonpreferred pharmacy Ded + $85/Mail order Ded + $225		
- **Tier 4:** Preferred Specialty Drugs	Preferred pharmacy 20% Coinsurance			Preferred pharmacy Ded + 30% Coinsurance		
- **Tier 5:** Nonpreferred Specialty Drugs	Preferred pharmacy 30% Coinsurance			Preferred pharmacy 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.

Coventry*One* is a health insurance product underwritten 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 Individual Policy, Schedule of Payments, and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

CoventryOne®

SC Individual Exchange Plans

Carelink-Roper St. Francis Network

PLAN BENEFITS	Bronze $15 Copay			Bronze 100% HSA Eligible		Catastrophic	
	Tier 1 Roper St. Francis	Tier 2 CHC Carolinas POS Network	Tier 3 Out-of-Network	In-Network Roper St. Francis	Out-of-Network	In-Network Roper St. Francis	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/Coins	Ded	Not Covered	First 3 visits: $20 Copay; 4+ visits: Ded	Not Covered
Specialist Office Visit (Spec) ***referral from PCP required***	First Visit: $75; 2+ Visits: $75 Copay + Ded	$100 Copay + Ded	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	Ded/Coins	$0	Not Covered	$0	Not Covered
Lab/Radiology* **	Incl in PCP office visit; Spec/Outpt: Ded/Coins	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 + Coins	PCP/Spec/Outpt:$500 Copay + Ded/Coins; Free- standing Facility: Ded + Coins	Ded	Not Covered	Ded	Not Covered
Convenience Care	$25 Copay	Ded/Coins	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Urgent Care	$150 Copay	$150 Copay + Ded.	Ded/Coins	Ded	Not Covered	Ded	Not Covered
Emergency Care	First Visit: $500 Copay; 2+ Visits: $500 Copay + Ded	$750 Copay + Ded/Coins	$750 Copay + Ded/ 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, Speech) *Physical Therapy limited to 30 days*	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 Ded/ Physician charges: Ded; 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/Outpt: Ded/Coins.; Inpt: $1,000 Admit + Ded/Coins	Office/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
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	Preferred pharmacy $15/Nonpreferred pharmacy $20/Mail order $30			Ded		Ded	
- **Tier 2:** Preferred Brand Drugs	Preferred pharmacy Ded + $45/ Nonpreferred pharmacy Ded + $55/ Mail order Ded + $112.50			Ded		Ded	
- **Tier 3:** Nonpreferred Brand/Generic Drugs	Preferred pharmacy Ded + $75/ Nonpreferred pharmacy Ded + $85/Mail order Ded + $225			Ded		Ded	
- **Tier 4:** Preferred Specialty Drugs	Preferred pharmacy Ded + 30% Coinsurance			Ded		Ded	
- **Tier 5:** Nonpreferred Specialty Drugs	Preferred pharmacy Ded + 40% Coinsurance			Ded		Ded	