

# South Carolina CoventryOne Health Plan Network Options

Choose one of the provider networks listed below, then choose one of the plans on the following pages.

Provider network	Counties	Network type	Out-of-network coverage
<b>Carolinas HealthCare</b>	Lancaster, York	Carelink high-performance	Depends on plan
<b>Roper St. Francis</b>	Berkeley, Charleston, Dorchester	Carelink high-performance	Depends on plan
<b>Regional HealthPlus</b>	Spartanburg	Carelink high-performance	Depends on plan
<b>Midlands</b>	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg, Richland, Sumter	Carelink high-performance	Depends on plan
<b>Upstate</b>	Greenville	Carelink high-performance	Depends on plan
<b>CoventryOne POS On Exchange</b>	Florence	Full	Yes
<b>CoventryOne POS Off Exchange</b>	Anderson, Beaufort, Cherokee, Chester, Chesterfield, Colleton, Darlington, Florence, Lee, Marion, Marlboro, Pickens, Union	Full	Yes

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# Catastrophic CoventryOne Health Plan option in South Carolina

Plan	SC Coventry Catastrophic 100% Carelink PD
Member benefits	In network
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$6,600/\$13,200
<b>Member coinsurance</b>	0%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,600/\$13,200
<b>Primary care visit</b>	Visits 1–3: \$20 copay; ded waived Visits 4+: Covered in full after ded
<b>Specialist visit</b>	Covered in full after ded
<b>Hospital stay</b>	Covered in full after ded
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	Covered in full after ded
<b>Emergency room</b>	Covered in full after ded
<b>Urgent care</b>	Covered in full after ded
<b>Preventive care</b> (age and frequency limits apply)	Covered in full; ded waived
<b>Diagnostic lab</b>	Covered in full after ded
<b>Diagnostic X-ray</b>	Covered in full after ded
<b>Imaging</b> (CT/PET scans, MRIs)	Covered in full after ded
Vision	
<b>Pediatric eye exam</b> (1 visit per year)	Covered in full after ded
Pediatric dental	
<b>Dental checkup/preventive dental care</b> (2 visits per year)	Covered in full; ded waived
<b>Basic dental care</b>	Covered in full after ded
Pharmacy*	
<b>Pharmacy deductible</b>	Integrated with medical ded
<b>Preferred generic drugs</b>	Covered in full after ded
<b>Preferred brand drugs</b>	Covered in full after ded
<b>Nonpreferred drugs**</b>	Covered in full after ded
<b>Specialty drugs***</b>	Covered in full 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.

<sup>1</sup>The 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.

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# Bronze CoventryOne Health Plan options in South Carolina

Plan	SC Coventry Bronze Ded Only HSA Elig Carelink PD
Member benefits	In network
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$6,300/\$12,600 <sup>1</sup>
<b>Member coinsurance</b>	0%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,300/\$12,600
<b>Primary care visit</b>	Covered in full after ded
<b>Specialist visit</b>	Covered in full after ded
<b>Hospital stay</b>	Covered in full after ded
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	Covered in full after ded
<b>Emergency room</b>	Covered in full after ded
<b>Urgent care</b>	Covered in full after ded
<b>Preventive care</b> (age and frequency limits apply)	Covered in full; ded waived
<b>Diagnostic lab</b>	Covered in full after ded
<b>Diagnostic X-ray</b>	Covered in full after ded
<b>Imaging</b> (CT/PET scans, MRIs)	Covered in full after ded
<b>Vision</b>	
<b>Pediatric eye exam</b> (1 visit per year)	Covered in full; ded waived
<b>Pediatric dental</b>	
<b>Dental checkup/preventive dental care</b> (2 visits per year)	Covered in full; ded waived
<b>Basic dental care</b>	Covered in full after ded
<b>Pharmacy*</b>	
<b>Pharmacy deductible</b>	Integrated with medical ded
<b>Preferred generic drugs</b>	Covered in full after ded
<b>Preferred brand drugs</b>	Covered in full after ded
<b>Nonpreferred drugs**</b>	Covered in full after ded
<b>Specialty drugs***</b>	Covered in full 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.

<sup>1</sup>The 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.

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# Bronze CoventryOne Health Plan options in South Carolina

(Continued)

## SC Coventry Bronze \$15 Copay Carelink PD

Tier 1	Tier 2	Tier 3
\$5,000/\$10,000 <sup>2</sup>	\$6,250/\$12,500 <sup>2</sup>	\$12,500/\$25,000 <sup>2</sup>
0%	0%	50%
\$6,600/\$13,200	\$6,600/\$13,200	Unlimited/unlimited
\$15 copay; ded waived	\$50 copay after ded	50% after ded
Visit 1: \$75 copay; ded waived Visits 2+: \$75 copay after ded	\$100 copay after ded	50% after ded
\$250 copay per admission after ded	\$500 copay per admission after ded	50% after ded
\$250 copay after ded	\$500 copay after ded	50% after ded
Visit 1: \$250 copay; ded waived Visits 2+: \$250 copay after ded	\$500 copay after ded	Paid at the non-designated level
\$60 copay after ded	\$150 copay after ded	50% after ded
Covered in full; ded waived	Covered in full; ded waived	50% after ded
Covered in full after ded	Covered in full after ded	50% after ded
\$100 copay after ded	\$200 copay after ded	50% after ded
\$250 copay after ded	\$500 copay after ded	50% after ded
Covered in full; ded waived <sup>3</sup>	Paid at the designated level <sup>3</sup>	50% after ded <sup>3</sup>
Covered in full; ded waived <sup>3</sup>	Paid at the designated level <sup>3</sup>	Covered in full; ded waived <sup>3</sup>
50% after ded	Paid at the designated level	50% after ded
Integrated with medical ded	Integrated with medical ded	Integrated with medical ded
P: \$20 copay; ded waived; NP: \$25 copay; ded waived	P: \$20 copay; ded waived; NP: \$25 copay; ded waived	50% after ded
P: \$45 copay after ded; NP: \$55 copay 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	P: \$75 copay after ded; NP: \$85 copay after ded	50% after ded
P: 40% after ded; NP: 50% after ded	P: 40% after ded; NP: 50% after ded	Not covered

<sup>2</sup>The 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 combined for designated and non-designated. Deductible and/or out-of-pocket limit are separate for out of network.

<sup>3</sup>Any applicable benefit maximums are combined designated, non-designated and out of network.

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# Silver CoventryOne Health Plan options in South Carolina

Plan	SC Coventry Silver \$10 Copay Carelink PD	
Member benefits	Tier 1	Tier 2
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$3,750/\$7,500	\$6,000/\$12,000
<b>Member coinsurance</b>	30%	40%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,250/\$12,500	\$6,600/\$13,200
<b>Primary care visit</b>	\$10 copay; ded waived	\$50 copay after ded
<b>Specialist visit</b>	Visit 1–2: \$60 copay; ded waived; Visits 3+: \$60 copay after ded	\$75 copay after ded
<b>Hospital stay</b>	\$250 copay per admission before ded; then 30%	\$500 copay per admission before ded; then 40%
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	\$250 copay after ded; then 30%	\$500 copay after ded; then 40%
<b>Emergency room</b> (copay waived if admitted)	Visit 1–2: \$250 copay; ded waived Visits 3+: \$250 copay after ded	\$500 copay after ded; then 40%
<b>Urgent care</b>	\$75 copay; ded waived	40% after ded
<b>Preventive care</b> (age and frequency limits apply)	Covered in full; ded waived	Covered in full; ded waived
<b>Diagnostic lab</b>	30% after ded	40% after ded
<b>Diagnostic X-ray</b>	30% after ded	40% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	\$250 copay after ded; then 30%	\$500 copay after ded; then 40%
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level
<b>Basic dental care</b>	50% after ded	Paid at the designated level
<b>Pharmacy*</b>		
<b>Pharmacy deductible</b>	\$500 per member/\$1,000 per family. Ded combined for tiers 1, 2 and 3.	\$500 per member/\$1,000 per family. Ded combined for tiers 1, 2 and 3.
<b>Preferred generic drugs**</b>	P: T1A-\$3 copay; ded waived/T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived	P: T1A-\$3 copay; ded waived/T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived
<b>Preferred brand drugs</b>	P: \$40 copay after ded; NP: \$50 copay after ded	P: \$40 copay after ded; NP: \$50 copay after ded
<b>Nonpreferred drugs***</b>	P: \$75 copay after ded; NP: \$85 copay after ded	P: \$75 copay after ded; NP: \$85 copay after ded
<b>Specialty drugs<sup>†</sup></b>	P: 40% after ded; NP: 50% after ded	P: 40% after ded; NP: 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.

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# Silver CoventryOne Health Plan options in South Carolina

(Continued)

## SC Coventry Silver \$10 Copay Carelink PD (continued)

Tier 3
\$11,500/\$23,000
50%
Unlimited/unlimited
50% after ded
50% after ded
\$1,000 copay per admission before ded; then 50%
\$500 copay after ded; then 50%
Paid as non designated
50% after ded
50% after ded
50% after ded
50% after ded
\$500 copay after ded; then 50%
50% after ded
Covered in full; ded waived
50% after ded
\$500 per member/\$1,000 per family. Ded combined for tiers 1, 2 and 3.
50% after ded
50% after ded
50% after ded
Not covered

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# Silver CoventryOne Health Plan options in South Carolina

Plan	SC Coventry Silver \$5 Copay 2750 Carelink PD	
Member benefits	Tier 1	Tier 2
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$2,750/\$5,500	\$5,750/\$11,500
<b>Member coinsurance</b>	30%	40%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,250/\$12,500	\$6,600/\$13,200
<b>Primary care visit</b>	\$5 copay; ded waived	\$50 copay after ded
<b>Specialist visit</b>	Visit 1 – 2: \$60 copay; ded waived Visits 3+: \$60 copay after ded	\$75 copay after ded
<b>Hospital stay</b>	30% after ded	\$500 copay per admission after ded; then 40%
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	30% after ded	\$250 copay after ded; then 40%
<b>Emergency room</b> (copay waived if admitted)	Visit 1 – 2: \$250 copay; ded waived Visits 3+: \$250 copay after ded	\$500 copay after ded
<b>Urgent care</b>	\$75 copay; ded waived	40% after ded
<b>Preventive care</b> (age and frequency limits apply)	Covered in full; ded waived	Covered in full; ded waived
<b>Diagnostic lab</b>	30% after ded	40% after ded
<b>Diagnostic X-ray</b>	30% after ded	40% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	30% after ded	\$250 copay after ded; then 40%
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level
<b>Basic dental care</b>	50% after ded	Paid at the designated level
<b>Pharmacy*</b>		
<b>Pharmacy deductible</b>	Integrated with medical ded	Integrated with medical ded
<b>Preferred generic drugs**</b>	P: T1A-\$3 copay; ded waived/ T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived	P: T1A-\$3 copay; ded waived/ T1-\$15 copay; ded waived; NP: T1A-\$20 copay; ded waived/ T1-\$20 copay; ded waived
<b>Preferred brand drugs</b>	P: \$40 copay after ded; NP: \$50 copay after ded	P: \$40 copay after ded; NP: \$50 copay after ded
<b>Nonpreferred drugs***</b>	P: \$70 copay after ded; NP: \$80 copay after ded	P: \$70 copay after ded; NP: \$80 copay after ded
<b>Specialty drugs<sup>†</sup></b>	P: 40% after ded; NP: 50% after ded	P: 40% after ded; NP: 50% after ded

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

\*\*\*Includes nonpreferred generic and brand drugs.

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# Silver CoventryOne Health Plan options in South Carolina

(Continued)

## SC Coventry Silver \$5 Copay 2750 Carelink PD (continued)

Tier 3
\$11,500/\$23,000
50%
Unlimited/unlimited
50% after ded
50% after ded
\$1,000 copay per admission after ded; then 50%
\$500 copay after ded; then 50%
Paid as non designated
50% after ded
50% after ded
50% after ded
50% after ded
\$250 copay after ded; then 50%
50% after ded
Covered in full; ded waived
50% after ded
Integrated with medical ded
50% after ded
50% after ded
50% after ded
Not covered

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 †The 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 combined for designated and non-designated. Deductible and/or out-of-pocket limit are separate for out of network.

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# Gold CoventryOne Health Plan option in South Carolina

Plan	SC Coventry Gold \$0 Copay Carelink PD		
Member benefits	Tier 1	Tier 2	Tier 3
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$1,250/\$2,500	\$3,500/\$7,000	\$6,750/\$13,500
<b>Member coinsurance</b>	20%	40%	50%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$4,250/\$8,500	\$6,000/\$12,000	Unlimited/unlimited
<b>Primary care visit</b>	Covered in full; ded waived	\$25 copay; ded waived	50% after ded
<b>Specialist visit</b>	Visit 1–5: \$50 copay; ded waived Visits 6+: \$50 copay; after ded	\$75 copay after ded	50% after ded
<b>Hospital stay</b>	20% after ded	\$250 copay per admission after ded; then 40%	\$1,000 copay per admission after ded; then 50%
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	20% after ded	40% after ded	50% after ded
<b>Emergency room</b> (copay waived if admitted)	Visit 1–3: \$250 copay; ded waived Visits 4+: \$250 copay after ded	\$250 copay after ded	Paid as non-designated
<b>Urgent care</b>	\$75 copay; ded waived	\$150 copay; ded waived	50% after ded
<b>Preventive care</b> (age and frequency limits apply)	Covered in full; ded waived	Covered in full; ded waived	50% after ded
<b>Diagnostic lab</b>	20% after ded	40% after ded	50% after ded
<b>Diagnostic X-ray</b>	20% after ded	40% after ded	50% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	20% after ded	40% after ded	50% after ded
<b>Vision</b>			
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level	50% after ded
<b>Pediatric dental</b>			
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Paid at the designated level	Covered in full; ded waived
<b>Basic dental care</b>	50% after ded	Paid at the designated level	50% after ded
<b>Pharmacy<sup>*</sup></b>			
<b>Pharmacy deductible</b>	None	None	None
<b>Preferred generic drugs<sup>**</sup></b>	P: T1A-\$3 copay/T1-\$10 copay; NP: T1A-\$10 copay/T1-\$15 copay	P: T1A-\$3 copay/T1-\$10 copay; NP: T1A-\$10 copay/T1-\$15 copay	50%
<b>Preferred brand drugs</b>	P: \$30 copay; NP: \$40 copay	P: \$30 copay; NP: \$40 copay	50%
<b>Nonpreferred drugs<sup>***</sup></b>	P: \$55 copay; NP: \$65 copay	P: \$55 copay; NP: \$65 copay	50%
<b>Specialty drugs<sup>†</sup></b>	P: 30%; NP: 50%	P: 30%; NP: 50%	Not covered

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

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

\*\*\*Includes nonpreferred generic and brand drugs.

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<sup>2</sup>Any applicable benefit maximums are combined designated, non-designated and out of network.

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# Catasrophic CoventryOne Health Plan option in South Carolina

Plan	SC Coventry Catastrophic 100% PD	
Member benefits	In network	Out of network
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$6,600/\$13,200	\$13,500/\$27,000
<b>Member coinsurance</b>	0%	50%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,600/\$13,200	Unlimited/unlimited
<b>Primary care visit</b>	Visits 1–3: \$20 copay; ded waived Visits 4+: Covered in full after ded	50% after ded
<b>Specialist visit</b>	Covered in full after ded	50% after ded
<b>Hospital stay</b>	Covered in full after ded	50% after ded
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	Covered in full after ded	50% after ded
<b>Emergency room</b>	Covered in full after ded	Covered in full after ded
<b>Urgent care</b>	Covered in full after ded	50% after ded
<b>Preventive care</b> (age and frequency visit limits apply)	Covered in full; ded waived	50% after ded
<b>Diagnostic lab</b>	Covered in full after ded	50% after ded
<b>Diagnostic X-ray</b>	Covered in full after ded	50% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	Covered in full after ded	50% after ded
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full after ded	50% after ded
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Covered in full; ded waived
<b>Basic dental care</b>	Covered in full after ded	Covered in full after ded
<b>Pharmacy*</b>		
<b>Pharmacy deductible</b>	Integrated with medical ded	Integrated with medical ded
<b>Preferred generic drugs</b>	Covered in full after ded	50% after ded
<b>Preferred brand drugs</b>	Covered in full after ded	50% after ded
<b>Nonpreferred drugs**</b>	Covered in full after ded	50% after ded
<b>Specialty drugs***</b>	Covered in full after ded	Not covered

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

\*\*Includes nonpreferred generic and brand drugs.

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

<sup>1</sup>The 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.

<sup>2</sup>Any applicable benefit maximums are combined in and out of network.

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# Bronze CoventryOne Health Plan options in South Carolina

Plan	SC Coventry Bronze Deductible Only HSA Eligible PD	
	In network	Out of network
<b>Member benefits</b>		
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$6,300/\$12,600	\$12,600/\$25,200
<b>Member coinsurance</b>	0%	50%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,300/\$12,600	Unlimited/unlimited
<b>Primary care visit</b>	Covered in full after ded	50% after ded
<b>Specialist visit</b>	Covered in full after ded	50% after ded
<b>Hospital stay</b>	Covered in full after ded	50% after ded
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	Covered in full after ded	50% after ded
<b>Emergency room</b>	Covered in full after ded	Covered in full after ded
<b>Urgent care</b>	Covered in full after ded	50% after ded
<b>Preventive care</b> (age and frequency visit limits apply)	Covered in full; ded waived	50% after ded
<b>Diagnostic lab</b>	Covered in full after ded	50% after ded
<b>Diagnostic X-ray</b>	Covered in full after ded	50% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	Covered in full after ded	50% after ded
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	50% after ded
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Covered in full; ded waived
<b>Basic dental care</b>	Covered in full after ded	Covered in full after ded
<b>Pharmacy*</b>		
<b>Pharmacy deductible</b>	Integrated with medical ded	Integrated with medical ded
<b>Preferred generic drugs</b>	Covered in full after ded	50% after ded
<b>Preferred brand drugs</b>	Covered in full after ded	50% after ded
<b>Nonpreferred drugs**</b>	Covered in full after ded	50% after ded
<b>Specialty drugs***</b>	Covered in full after ded	Not covered

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

\*\*Includes nonpreferred generic and brand drugs.

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

<sup>1</sup>The 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.

<sup>2</sup>Any applicable benefit maximums are combined in and out of network.

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# Bronze CoventryOne Health Plan options in South Carolina

(Continued)

## SC Coventry Bronze \$20 Copay PD

In network	Out of network
\$5,750/\$11,500	\$11,500/\$23,000
0%	50%
\$6,600/\$13,200	Unlimited/unlimited
\$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
Covered in full; ded waived	Covered in full; ded waived
50% after ded	50% after ded
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	Not covered

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# Silver CoventryOne Health Plan options in South Carolina

Plan	SC Coventry Silver \$10 Copay PD	
Member benefits	In network	Out of network
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$3,750/\$7,500	\$7,500/\$15,000
<b>Member coinsurance</b>	30%	50%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$6,600/\$13,200	Unlimited/unlimited
<b>Primary care visit</b>	\$10 copay; ded waived	50% after ded
<b>Specialist visit</b>	Visit 1–2: \$75 copay; ded waived Visits 3+: \$75 copay after ded	50% after ded
<b>Hospital stay</b>	\$500 copay per admission before ded; then 30%	\$1,000 copay per admission before ded; then 50%
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	\$250 copay after ded; then 30%	\$250 copay after ded; then 50%
<b>Emergency room</b> (copay waived if admitted)	Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded	Visit 1: \$500 copay; ded waived Visits 2+: \$500 copay after ded
<b>Urgent care</b>	\$75 copay; ded waived	50% after ded
<b>Preventive care</b> (age and frequency visit limits apply)	Covered in full; ded waived	50% after ded
<b>Diagnostic lab</b>	30% after ded	50% after ded
<b>Diagnostic X-ray</b>	30% after ded	50% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	\$250 copay after ded; then 30%	\$250 copay after ded; then 50%
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	50% after ded
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Covered in full; ded waived
<b>Basic dental care</b>	50% after ded	50% after ded
<b>Pharmacy<sup>*</sup></b>		
<b>Pharmacy deductible</b>	\$500 per member/\$1,000 per family. Ded combined in and out of network.	\$500 per member/\$1,000 per family. Ded combined in and out of network.
<b>Preferred generic drugs<sup>**</sup></b>	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
<b>Preferred brand drugs</b>	P: \$45 copay after ded; NP: \$55 copay after ded	50% after ded
<b>Nonpreferred drugs<sup>***</sup></b>	P: \$75 copay after ded; NP: \$85 copay after ded	50% after ded
<b>Specialty drugs<sup>†</sup></b>	P: 40% after ded; NP: 50% after ded	Not covered

\*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.

<sup>1</sup>The 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.

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# Silver CoventryOne Health Plan options in South Carolina

(Continued)

## SC Coventry Silver \$5 Copay 2750 PD

In network	Out of network
\$2,750/\$5,500	\$7,500/\$15,000
40%	50%
\$6,600/\$13,200	Unlimited/unlimited
\$5 copay; ded waived	50% after ded
Visit 1–2: \$75 copay; ded waived Visits 3+: \$75 copay after ded	50% after ded
40% after ded	\$1,000 copay per admission after ded; then 50%
40% after ded	\$250 copay after ded; then 50%
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
40% after ded	50% after ded
40% after ded	50% after ded
40% after ded	\$250 copay after ded; then 50%
Covered in full; ded waived	50% after ded
Covered in full; ded waived	Covered in full; ded waived
50% after ded	50% after ded
Integrated with medical ded	Integrated with medical ded
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	Not covered

<sup>2</sup>Any applicable benefit maximums are combined in and out of network.

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# Gold CoventryOne Health Plan option in South Carolina

Plan	SC Coventry Gold \$5 Copay PD	
Member benefits	In network	Out of network
<b>Deductible (ded) individual/family<sup>1</sup></b> (applies to out-of-pocket maximum)	\$1,400/\$2,800	\$6,750/\$13,500
<b>Member coinsurance</b>	20%	50%
<b>Out-of-pocket maximum individual/family<sup>1</sup></b> (maximum you will pay for all covered services)	\$5,650/\$11,300	Unlimited/unlimited
<b>Primary care visit</b>	\$5 copay; ded waived	50% after ded
<b>Specialist visit</b>	Visit 1–5: \$50 copay; ded waived Visits 6+: \$50 copay after ded	50% after ded
<b>Hospital stay</b>	20% after ded	\$1,000 copay per admission after ded; then 50%
<b>Outpatient surgery</b> (ambulatory surgical center/hospital)	20% after ded	50% after ded
<b>Emergency room</b> (copay waived if admitted)	Visit 1–3: \$250 copay; ded waived Visits 4+: \$250 copay after ded	Paid as in network
<b>Urgent care</b>	\$75 copay; ded waived	50% after ded
<b>Preventive care</b> (age and frequency visit limits apply)	Covered in full; ded waived	50% after ded
<b>Diagnostic lab</b>	20% after ded	50% after ded
<b>Diagnostic X-ray</b>	20% after ded	50% after ded
<b>Imaging</b> (CT/PET scans, MRIs)	20% after ded	50% after ded
<b>Vision</b>		
<b>Pediatric eye exam</b> (1 visit per year) <sup>2</sup>	Covered in full; ded waived	50% after ded
<b>Pediatric dental</b>		
<b>Dental checkup/preventive dental care</b> (2 visits per year) <sup>2</sup>	Covered in full; ded waived	Covered in full; ded waived
<b>Basic dental care</b>	50% after ded	50% after ded
<b>Pharmacy*</b>		
<b>Pharmacy deductible</b>	\$250 per member/\$500 per family. Ded combined in and out of network.	\$250 per member/\$500 per family. Ded combined in and out of network.
<b>Preferred generic drugs**</b>	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
<b>Preferred brand drugs</b>	P: \$35 copay after ded; NP: \$45 copay after ded	50% after ded
<b>Nonpreferred drugs***</b>	P: \$65 copay after ded; NP: \$80 copay after ded	50% after ded
<b>Specialty drugs<sup>†</sup></b>	P: 30% after ded; NP: 50% after ded	Not covered

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

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

\*\*\*Includes nonpreferred generic and brand drugs.

<sup>†</sup>P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

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