WV HMO Individual Plans off the Exchange

PLAN BENEFITS	Gold $5 Copay Plan	Silver $10 Copay Plan	Bronze $10 Copay Plan	Bronze Deductible Only HSA Eligible Plan	Catastrophic 100% Plan
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible (per calendar year, Individual/Family)	$1,750 Individual $3,500 Family	$3,750 Individual $7,500 Family	$5,600 Individual $11,200 Family	$6,300 Individual $12,600 Family	$6,350 Individual** $12,700 Family**
Coinsurance	20%	30%	30%	0%	0%
Out-of-Pocket Maximum* (per calendar year, Individual/Family)	$5,000 Individual $10,000 Family	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family	$6,300 Individual $12,600 Family	$6,350 Individual** $12,700 Family**
Medical benefits shown with Copays are not subject to Deductibles unless specified					
Primary Physician Office Visit (PCP)	$5 Copay	$10 Copay	$10 Copay	Deductible	First 3 visits: $20 Copay; 4+ visits: Deductible
Specialist Office Visit	First 5 visits: $50; 6+ visits $50 Copay + Deductible	First visit: $75; 2+ visits $75 Copay + Deductible	$75 Copay + Deductible	Deductible	Deductible
Preventive/Wellness Services (adult, child and well baby care, mammograms, pap smears, PSA testing, immunizations)	$0	$0	$0	$0	$0
Lab/Radiology* **	Included in PCP office visit; Specialist/Outpatient: Deductible/Coinsurance	Included in PCP office visit; Specialist/Outpatient:Deductible/Coinsurance	Included in PCP office visit; Specialist/Outpatient:Deductible/Coinsurance	Deductible	Deductible
Advanced Imaging/HighTech Radiology	PCP/Specialist/Outpatient: Deductible/Coinsurance; Free-standing Facility: $250 Copay	PCP/Specialist/Outpatient: $250 Copay + Deductible/Coinsurance; Free-standing Facility:$250 Copay + Deductible	PCP/Specialist/Outpatient: $250 Copay + Deductible/Coinsurance; Free-standing Facility:$250 Copay + Deductible	Deductible	Deductible
Convenience Care	$25 Copay	$25 Copay	$25 Copay	Deductible	Deductible
Urgent Care	$75 Copay	$75 Copay	$75 Copay + Deductible	Deductible	Deductible
Emergency Care	First 3 visits: $250 Copay; 4+ visits: $250 Copay + Deductible	First visit: $500 Copay; 2+ visits: $500 Copay + Deductible	$500 Copay + Deductible	Deductible	Deductible
Inpatient Hospitalization (Physician and surgical services)	Deductible/Coinsurance	$500 Copay + Deductible/Coinsurance	$500 Copay + Deductible/Coinsurance	Deductible	Deductible
Outpatient Facility and Physician Services/Home Health Care/Hospice/Skilled Nursing Facility	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible
Rehabilitation Services (Physical, Speech, Occupational, Respiratory). *Up to 30 visits for all therapies combined*	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible	Deductible
Maternity and Newborn Care	Prenatal office visits: $0 Copay; Physician: $250 one-time Copay; Inpatient: Deductible/Coinsurance	Prenatal office visits: $0 Copay; Physician: $250 one-time Copay; Inpatient: $500 Copay + Deductible/Coinsurance	Prenatal office visits: $0 Copay: Physician: $500 one-time Copay; Inpatient: $500 Copay + Deductible/Coinsurance	Prenatal office visits: $0 Copay; Physician/Inpatient: Deductible	Prenatal office visits: $0 Copay; Physician/Inpatient: Deductible
Mental Health Office Visit/Outpatient/Inpatient**	First 5 office visits: $50 Copay; 6+ visits: $50 Copay + Deductible; Outpatient/Inpatient Deductible/Coinsurance	First office visit: $75 Copay; 2+ visits: $75 Copay + Deductible; Outpatient: Deductible/Coinsurance; Inpatient: $500 Copay + Deductible/Coinsurance	Office visit: $75 Copay + Deductible; Outpatient: Deductible/Coinsurance; Inpatient: $500 Copay + Deductible/Coinsurance	Deductible	Deductible
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.
Pediatric Dental	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance	Preventive/Diagnostic Svcs: 0% Basic/Major Svcs: Deductible + 50% Coinsurance
Pharmacy	**Separate $250 Single/$500 Family Rx Deductible on Tiers 2-5**	**Separate $1000 Single/$2000 Family Rx Deductible on Tiers 2-5**	**Integrated Medical/RX Deductible Tiers 2-5**	**Integrated Medical/Rx Deductible**	**Integrated Medical/Rx Deductible**
- **Tier 1A:** Lower Cost Preferred Generic Drugs	No Deductible; Preferred pharmacy $3; Non-preferred 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	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; Non-preferred pharmacy: Deductible + $75; Mail order: Deductible + $180	Preferred pharmacy: Deductible + $75; Nonpreferred pharmacy: Deductible + $85;	Preferred pharmacy: Deductible + $75; Nonpreferred pharmacy Deductible + $85;	Deductible	Deductible
- **Tier 4:** Preferred Specialty Drugs	Pharmacy Deductible + 20% Coinsurance	Preferred pharmacy: Deductible + 30% Coinsurance	Preferred pharmacy: Deductible + 30% Coinsurance	Deductible	Deductible
- **Tier 5:** Nonpreferred Specialty Drugs	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. Pediatric vision and dental benefits are only available for children who are under the age of 19 on Jan. 1st of the calendar year.

CoventryOne is a health insurance product underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care. 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.