HealthAmericaOne.
A Coventry Health Care Plan

Ohio PPO 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 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/Free-standing Facility: $250 Copay+ Deductible/Coinsurance	PCP/Specialist/Outpatient: Deductible/ Coinsurance; Free-standing Facility: Deductible/Coinsurance	PCP/Specialist/Free-standing Facility/Outpatient: $250 Copay+ Deductible/Coinsurance	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	$75 Copay	$75 Copay	$75 Copay	$75 Copay + Deductible	$75 Copay + Deductible	Deductible	Deductible	Deductible	Deductible
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 20 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, subject to deductible; one routine eye exam, subject to deductible.	
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 Deductible on Tiers 2-5		Separate $1,000 Single/$2000 Family 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. Pediatric vision and dental benefits are only available for children who are under the age of 19 on Jan. 1st of the calendar year".

Coventry*One* 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.