

CoventryOne.

	HEALTHGEAR			
	HG A2500	HG A5000	HG B3500	HG C5000
Member Responsibility				
In-Network Benefits				
Medical Services				
Deductible (per benefit year, family is 2x)	\$2,500	\$5,000	\$3,500	\$5,000
Coinsurance	20%		30%	40%
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$7,500	\$10,000	\$8,500	\$10,000
Maximum Annual Benefit	\$2 million combined In and Out-of-Network			
Maximum Lifetime Benefit	Unlimited			
Physician Office Services (Family Practice, General Practice, Internal Medicine, Pediatrics, OBGYN)	\$40 copay 4 maximum*		\$40 copay 3 maximum*	\$40 copay 2 maximum*
Specialty Physician Office Services	\$60 copay 4 maximum*		\$60 copay 3 maximum*	\$60 copay 2 maximum*
Preventive Services	0% coinsurance not subject to deductible			
Complications of Pregnancy Only (Maternity Services Not Covered)	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Inpatient Hospital Services	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Transplants	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Outpatient Hospital Services	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Short Term Therapies (visit limits apply)	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Spinal Manipulation	Not covered			
Nursing Facility (60 day limit)	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Home Health Care (60 visit limit)	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Hospice	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Prosthetics & DME	Ded. then 20% coins.	Ded. then 20% coins.	Ded. then 30% coins.	Ded. then 40% coins.
Urgent Care Services	\$150 copay then coinsurance			
Emergency Room	\$500 copay then coinsurance			
Prescription Drug Coverage				
Tier 1 - Formulary Generic	\$15 copay			
Tier 2 - Formulary Brand	Not covered			
Tier 3 - Non-formulary	Not covered			
Mental Health				
Inpatient Care	Not covered			
Outpatient Care	Not covered			
Out-of-Network Benefits				
Deductible (per benefit year, family is 2x)	\$5,000	\$10,000	\$7,000	\$10,000
Coinsurance	50%			
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$15,000	\$20,000	\$17,000	\$20,000

This summary is a partial description of coverage. This policy has exclusions, limitations, reductions and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or Coventry. * Per benefit year all office visits, including specialty and out-of-network, accumulate toward maximum.

CoventryOne.

	SPECTRUM	
	Spectrum 1500	Spectrum 3500
Member Responsibility		
In-Network Benefits		
Medical Services		
Deductible (per benefit year, family is 2x)	\$1,500	\$3,500
Coinsurance	10%	
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$4,000	\$6,000
Maximum Lifetime Benefit	Unlimited	
Physician Office Services (Family Practice, General Practice, Internal Medicine, Pediatrics, OBGYN)	\$20 copay	
Specialty Physician Office Services	\$40 copay	
Preventive Services	0% coinsurance not subject to deductible	
Complications of Pregnancy Only (Maternity Services Not Covered)	Deductible then 10% coinsurance	
Inpatient Hospital Services	Deductible then 10% coinsurance	
Transplants	Deductible then 10% coinsurance	
Outpatient Hospital Services	Deductible then 10% coinsurance	
Short Term Therapies (visit limits apply)	Deductible then 10% coinsurance	
Spinal Manipulation (12 visit limit)	\$20 copay	
Nursing Facility (60 day limit)	Deductible then 10% coinsurance	
Home Health Care (60 visit limit)	Deductible then 10% coinsurance	
Hospice	Deductible then 10% coinsurance	
Prosthetics & DME	Deductible then 10% coinsurance	
Urgent Care Services	\$40 copay	
Emergency Room	\$150 copay	
Prescription Drug Coverage		
\$100 deductible then:		
Tier 1 - Formulary Generic	\$10 (deductible waived)	
Tier 2 - Formulary Brand	\$30 copay	
Tier 3 - Non-formulary	\$55 copay	
Mental Health (in-network only)		
Inpatient Care (30 days/benefit year)	50%	
Outpatient Care (20 visits/benefit year)	50%	
Out-of-Network Benefits		
Deductible (per benefit year, family is 2x)	\$3,000	\$7,000
Coinsurance	30%	
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$8,000	\$12,000

IOWA, NEBRASKA & SOUTH DAKOTA



	TORCH				TORCHLIGHT				PRISM		
	Torch 1000	Torch 1500	Torch 2500	Torch 5000	TorchLight 2000	TorchLight 3000	TorchLight 5000	TorchLight 10000	Prism 2500	Prism 3500	Prism 5000
	Member Responsibility				Member Responsibility				Member Responsibility		
In-Network Benefits											
Medical Services											
Deductible (per benefit year, family is 2x. Deductibles for Prism plans are aggregate)	\$1,000	\$1,500	\$2,500	\$5,000	\$2,000	\$3,000	\$5,000	\$10,000	\$2,500	\$3,500	\$5,000
Coinsurance	20%				40%				0%		
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$3,500	\$4,000	\$5,000	\$7,500	\$5,000	\$6,000	\$8,000	\$13,000	\$2,500	\$3,500	\$5,000
Maximum Lifetime Benefit	Unlimited				Unlimited				Unlimited		
Physician Office Services (Family Practice, General Practice, Internal Medicine, Pediatrics, OBGYN)	\$30 copay				\$30 copay				Deductible then 0% coinsurance		
Specialty Physician Office Services	\$60 copay				\$60 copay				Deductible then 0% coinsurance		
Preventive Services	0% coinsurance not subject to deductible				0% coinsurance not subject to deductible				0% coinsurance not subject to deductible		
Complications of Pregnancy Only (Maternity Services Not Covered)	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Inpatient Hospital Services	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Transplants	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Outpatient Hospital Services	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Short Term Therapies (visit limits apply)	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Spinal Manipulation (12 visit limit)	\$30 copay				\$30 copay				Deductible then 0% coinsurance		
Nursing Facility (60 day limit)	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Home Health Care (60 visit limit)	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Hospice	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Prosthetics & DME	Deductible then 20% coinsurance				Deductible then 40% coinsurance				Deductible then 0% coinsurance		
Urgent Care Services	\$50 copay				\$50 copay				Deductible then 0% coinsurance		
Emergency Room	\$150 then 20% coinsurance				\$150 then 40% coinsurance				Deductible then 0% coinsurance		
Prescription Drug Coverage	\$100 deductible then:				\$500 deductible then:						
Tier 1 - Formulary Generic	\$10 (deductible waived)				\$10 (deductible waived)				Deductible then 0% coinsurance		
Tier 2 - Formulary Brand	\$30 copay				\$40 copay				Deductible then 0% coinsurance		
Tier 3 - Non-formulary	\$55 copay				\$75 copay				Deductible then 0% coinsurance		
Mental Health											
Inpatient Care	Not covered				Not covered				Not covered		
Outpatient Care	Not covered				Not covered				Not covered		
Out-of-Network Benefits											
Deductible (per benefit year, family is 2x. Deductibles for Prism plans are aggregate)	\$2,000	\$3,000	\$5,000	\$10,000	\$4,000	\$6,000	\$10,000	\$20,000	\$5,000	\$7,000	\$10,000
Coinsurance	40%				50%				40%		
Out-of-Pocket Maximum (per benefit year, family is 2x)	\$7,000	\$8,000	\$10,000	\$15,000	\$10,000	\$12,000	\$16,000	\$26,000	\$7,000	\$9,000	\$12,000