



**INDIVIDUAL PLANS**

INDIVIDUAL PLAN BENEFITS:	KI08C05020 20		KI08C10025 20		KI08C20040 25		KI08C25045 25		KI08C30050 30	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime maximum</b>	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
<b>Deductible</b> (per contract year)	\$500 Individual \$1,500 Family	\$500 Individual \$1,500 Family	\$1,000 Individual \$3,000 Family	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family	\$2,000 Individual \$6,000 Family	\$2,500 Individual \$7,500 Family	\$2,500 Individual \$7,500 Family	\$3,000 Individual \$9,000 Family	\$3,000 Individual \$9,000 Family
<b>Coinsurance</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Out-of-pocket maximum</b> (per contract year) Includes coinsurance only	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family	\$2,500 Individual \$7,500 Family	\$5,000 Individual \$15,000 Family	\$4,000 Individual \$12,000 Family	\$8,000 Individual \$24,000 Family	\$4,500 Individual \$13,500 Family	\$9,000 Individual \$27,000 Family	\$5,000 Individual \$15,000 Family	\$10,000 Individual \$30,000 Family
<b>Medical benefits shown w/ copays not subject to deductibles</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>
<b>PCP office visit</b>	\$20 Copay	Deductible plus 40%	\$20 Copay	Deductible plus 40%	\$25 Copay	Deductible plus 40%	\$25 Copay	Deductible plus 40%	\$30 Copay	Deductible plus 40%
<b>Specialists office visit</b>	\$35 Copay	Deductible plus 40%	\$35 Copay	Deductible plus 40%	\$40 Copay	Deductible plus 40%	\$40 Copay	Deductible plus 40%	\$45 Copay	Deductible plus 40%
<b>Mammograms</b>	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%
<b>Emergency room services</b> - Copay waived if admitted to hospital	\$100 Copay plus 20%	\$100 Copay plus 20%	\$100 Copay plus 20%	\$100 Copay plus 20%	\$125 Copay plus 20%	\$125 Copay plus 20%	\$125 Copay plus 20%	\$125 Copay plus 20%	\$150 Copay plus 20%	\$150 Copay plus 20%
<b>Urgent care services</b>	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$100 Copay	\$100 Copay
<b>Ambulance</b> - When medically necessary	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%
<b>Inpatient hospital</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Outpatient hospital / facility</b> (X-ray, lab, diagnostic services, MRI, CAT & PET scans, surgery, anesthesia, etc.)	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Short term rehabilitation services</b> (physical, speech and occupational therapies) - Limited to 20 visits per therapy per contract	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Spinal manipulation services</b> - Limited to 26 visits per contract year	Same as physician office visit	Deductible plus 40%	Same as physician office visit	Deductible plus 40%	Same as physician office visit	Deductible plus 40%	Same as physician office visit	Deductible plus 40%	Same as physician office visit	Deductible plus 40%
<b>DME, prosthetics</b> - Limited to \$3,000 per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Organ transplants</b> - Limited to \$500,000 lifetime benefit maximum	See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits	
<b>Home health care</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Skilled nursing facility</b> - Limited to 60 days per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Hospice</b> - Inpatient limited to 15 days per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
<b>Prescription drugs</b> - Tier 1 - preferred generic - Tier 2 - preferred formulary brand - Tier 3 - non-preferred drugs	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider
<b>Mental health and substance abuse</b> - Outpatient: limited to 30 visits per contract yr. - Inpatient: limited to 30 days per contract yr.	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits

CoventryOne is a health insurance product underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Kansas, Inc. This information is a partial description of the benefits and in no way details all of the benefits, limits of the plan. Please refer to the Individual Policy, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

Benefit limitations are a combination of in-network and out-of-network benefits.  
\* These plans are qualified high deductible health plans and may be used with a Health Savings Account.



**INDIVIDUAL PLANS**

INDIVIDUAL PLAN BENEFITS:	KI08C50075 99		KI08C500150 99		KI08F20050 99		KI08A25025 30*		KI08A50050 20*	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime maximum</b>	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
<b>Deductible</b> (per contract year)	\$5,000 Individual \$15,000 Family	\$5,000 Individual \$15,000 Family	\$5,000 Individual \$15,000 Family	\$5,000 Individual \$15,000 Family	\$2,000 Individual \$6,000 Family	\$2,000 Individual \$6,000 Family	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family
<b>Coinsurance</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Out-of-pocket maximum</b> (per contract year) Includes coinsurance only	\$7,500 Individual \$22,500 Family	\$15,000 Individual \$45,000 Family	\$15,000 Individual \$45,000 Family	\$30,000 Individual \$90,000 Family	\$5,000 Individual \$15,000 Family	\$10,000 Individual \$30,000 Family	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>Medical benefits shown with copays not subject to deductibles</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>In-Network You Pay</b>	<b>Out-of-Network You Pay</b>
<b>PCP office visit</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Specialists office visit</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Mammograms</b>	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 70%	\$0 Copay	Deductible plus 20%	\$0 Copay	Deductible plus 20%
<b>Emergency room services</b> - Copay waived if admitted to hospital	\$150 Copay plus 20%	\$150 Copay plus 20%	\$200 Copay plus 20%	\$200 Copay plus 20%	\$125 Copay plus 50%	\$125 Copay plus 50%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%
<b>Urgent care services</b>	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 50%	Deductible plus 50%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%
<b>Ambulance</b> - When medically necessary	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 50%	Deductible plus 50%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%	Deductible plus 0%
<b>Inpatient hospital</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Outpatient hospital / facility</b> (X-ray, lab, diagnostic services, MRI, CAT & PET scans, surgery, anesthesia, etc.)	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Short term rehabilitation services</b> (physical, speech and occupational therapies) - Limited to 20 visits per therapy per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Spinal manipulation services</b> - Limited to 26 visits per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
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<b>Organ transplants</b> - Limited to \$500,000 lifetime benefit maximum	See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits	
<b>Home health care</b>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Skilled nursing facility</b> - Limited to 60 days per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Hospice</b> - Inpatient limited to 15 days per contract year	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%	Deductible plus 0%	Deductible plus 20%	Deductible plus 0%	Deductible plus 20%
<b>Prescription drugs</b> - Tier 1 - preferred generic - Tier 2 - preferred formulary brand - Tier 3 - non-preferred drugs	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	\$10 copay \$35 Copay \$60 Copay	See Rx Rider See Rx Rider See Rx Rider	Deductible plus 0% Deductible plus 0% Deductible plus 0%	See Rx Rider See Rx Rider See Rx Rider	Deductible plus 0% Deductible plus 0% Deductible plus 0%	See Rx Rider See Rx Rider See Rx Rider
<b>Mental health and substance abuse</b> - Outpatient: limited to 30 visits per contract yr. - Inpatient: limited to 30 days per contract yr.	See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits	

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