Coventry*One* Health Plan options in Georgia

	GA Coventry Catastrophic HMO* GA Coventry Catastrophic POS*	GA Coventry Bronze $15 Copay HMO GA Coventry Bronze $15 Copay POS
Member benefits	**In network you pay**	**In network you pay**
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$6,850/$13,700	$6,850/$13,700
Member coinsurance	0%	0%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,850/$13,700	$6,850/$13,700
Primary care visit	Visits 1–3: $20 copay; ded waived Visits 4+: Covered in full after ded	$15 copay; ded waived
Specialist visit	Covered in full after ded	Covered in full after ded
Hospital stay	Covered in full after ded	Covered in full after ded
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded	Covered in full after ded
Emergency room (copay waived if admitted)	Covered in full after ded	Covered in full after ded
Urgent care	Covered in full after ded	$100 copay; ded waived
Preventive care/screening/immunization (age and frequency visit limits apply)	Covered in full; ded waived	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived	Covered in full; ded waived
Diagnostic lab	Covered in full after ded	Covered in full after ded
Diagnostic X-ray	Covered in full after ded	Covered in full after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded	Covered in full after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full after ded	Covered in full; ded waived
Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)	Covered in full after ded	Covered in full; ded waived
Pediatric dental (off exchange only)		
Dental checkup/preventive dental care (2 visits per year)	Covered in full after ded	Covered in full; ded waived
Basic dental care	Covered in full after ded	Covered in full after ded
Major dental care	Covered in full after ded	Covered in full after ded
Orthodontia (medically necessary only)	Covered in full after ded	Covered in full after ded
Pharmacy		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	Generic: Covered in full after ded	Generic: Covered in full after ded
Preferred brand drugs	Covered in full after ded	Covered in full after ded
Nonpreferred drugs	Generic & Brand: Covered in full after ded	Generic & Brand: Covered in full after ded
Specialty drugs**	P: Covered in full after ded NP: Covered in full after ded	P: Covered in full after ded NP: Covered in full after ded

[1]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.

*Unlike metal-level coverage, this plan is a catastrophic plan offering. Only individuals who are younger than age 30 or have a hardship exemption may enroll in this plan.

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

Coventry*One* health benefits and insurance products are underwritten by Aetna Health Inc., dba Coventry Health Care of Georgia, Inc.

GA Coventry Bronze Deductible Only HSA Eligible HMO GA Coventry Bronze Deductible Only HSA Eligible POS	GA Coventry Silver $10 Copay HMO GA Coventry Silver $10 Copay POS	GA Coventry Silver $10 Copay 2750 HMO GA Coventry Silver $10 Copay 2750 POS
In network you pay	**In network you pay**	**In network you pay**
$6,450/$12,900	$3,500/$7,000	$2,750/$5,500
0%	30%	40%
$6,450/$12,900	$6,250/$12,500	$6,850/$13,700
Covered in full after ded	$10 copay; ded waived	$10 copay; ded waived
Covered in full after ded	$75 copay; ded waived	$75 copay; ded waived
Covered in full after ded	$500 copay per admission after ded; then 30%	40% after ded
Covered in full after ded	$250 copay after ded; then 30%	40% after ded
Covered in full after ded	$500 copay after ded	$500 copay after ded
Covered in full after ded	$75 copay; ded waived	$75 copay; ded waived
Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived
Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived
Covered in full after ded	30% after ded	40% after ded
Covered in full after ded	30% after ded	40% after ded
Covered in full after ded	$250 copay after ded; then 30%	40% after ded
Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived
Covered in full after ded	Covered in full; ded waived	Covered in full; ded waived
Covered in full after ded	Covered in full; ded waived	Covered in full; ded waived
Covered in full after ded	30% after ded	30% after ded
Covered in full after ded	50% after ded	50% after ded
Covered in full after ded	50% after ded	50% after ded
Integrated with medical ded	$500 per member	Integrated with medical ded
Generic: Covered in full after ded	Low Cost Generic: $5 copay; ded waived Generic: $15 copay; ded waived	Low Cost Generic: $5 copay; ded waived Generic: $15 copay; ded waived
Covered in full after ded	$40 copay after ded	$50 copay after ded
Generic & Brand: Covered in full after ded	Generic & Brand: $75 copay after ded	Generic & Brand: $80 copay after ded
P: Covered in full after ded NP: Covered in full after ded	P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after ded

This plan comparison guide shows in-network benefits only.

Out-of-network benefits are not available for HMO plans, except in an emergency.

Out-of-network benefits are available for Point of Service (POS) plans only. Below are some of the key out-of-network benefits for the POS plans:

All plans:
Member coinsurance: 50%
Out-of-pocket maximum: Unlimited

Catastrophic
- Deductible (individual/family): $13,700/$27,400

Bronze $15 Copay
- Deductible (individual/family): $13,700/$27,400

Bronze Deductible Only HSA
- Deductible (individual/family): $12,900/$25,800

Silver
- Deductible (individual/family): $7,500/$15,000

To learn more details about specific plans, including whether a plan includes out of network benefits, see the Summary of Benefits and Coverage at **http://www.sbcga.coventryone.com**

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 benefits, and applicable riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

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Coventry*One* Health Plan options in Georgia (continued)

Member benefits	GA Coventry Gold $10 Copay HMO GA Coventry Gold $10 Copay POS In network you pay
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$1,400/$2,800
Member coinsurance	20%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$5,000/$10,000
Primary care visit	$10 copay; ded waived
Specialist visit	$40 copay; ded waived
Hospital stay	20% after ded
Outpatient surgery (ambulatory surgical center/hospital)	20% after ded
Emergency room (copay waived if admitted)	$250 copay after ded
Urgent care	$75 copay; ded waived
Preventive care/screening/immunization (age and frequency visit limits apply)	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived
Diagnostic lab	20% after ded
Diagnostic X-ray	20% after ded
Imaging (CT/PET scans, MRIs)	20% after ded
Vision	
Pediatric eye exam (1 visit per year)	Covered in full; ded waived
Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)	Covered in full; ded waived
Pediatric dental (off exchange only)	
Dental checkup/preventive dental care (2 visits per year)	Covered in full; ded waived
Basic dental care	30% after ded
Major dental care	50% after ded
Orthodontia (medically necessary only)	50% after ded
Pharmacy	
Pharmacy deductible	$250 per member
Preferred generic drugs	Low Cost Generic: $3 copay; ded waived Generic: $10 copay; ded waived
Preferred brand drugs	$40 copay after ded
Nonpreferred drugs	Generic & Brand: $70 copay after ded
Specialty drugs*	P: 40% after ded NP: 50% after ded

This plan comparison guide shows in-network benefits only.

Out-of-network benefits are not available for HMO plans, except in an emergency.

Out-of-network benefits are available for Point of Service (POS) plans only. Below are some of the key out-of-network benefits for the POS plans:

- Deductible (individual/family): $6,750/$13,500
- Member coinsurance: 50%
- Out-of-pocket maximum: Unlimited

To learn more details about specific plans, including whether a plan includes out of network benefits, see the Summary of Benefits and Coverage at **http://www.sbcga.coventryone.com**

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 benefits, and applicable riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

[1]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.
*P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

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