On Exchange Catastrophic* Coventry Health Care of Virginia plan option

VA Coventry Catastrophic 100%
VA Coventry Catastrophic 100% Bon Secours
VA Coventry Catastrophic 100% Southside

Member benefits	In network you pay
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$6,850/$13,700
Member coinsurance	0%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,850/$13,700
Primary care visit	Visits 1 – 3: $20 copay; ded waived Visits 4+: Covered in full after ded
Specialist visit	Covered in full after ded
Hospital stay	Covered in full after ded
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded
Emergency room (copay waived if admitted)	Covered in full after ded
Urgent care	Covered in full after ded
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	Covered in full after ded
Diagnostic X-ray	Covered in full after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded
Vision	
Pediatric eye exam (1 visit per year)	Covered in full after ded
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
Pediatric dental	
Dental checkup/preventive dental care (2 visits per year)	Not covered
Basic dental care	Not covered
Major dental care	Not covered
Orthodontia (medically necessary only)	Not covered
Pharmacy	
Pharmacy deductible	Integrated with medical ded
Preferred generic drugs	Generic: Covered in full after ded
Preferred brand drugs	Covered in full after ded
Nonpreferred drugs	Generic & Brand: Covered in full after ded
Specialty drugs**	P: Covered in full after ded NP: Covered in full after ded

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[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.

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80.06.401.1-VA A (1/16)

On Exchange Bronze Coventry Health Care of Virginia plan options

Member benefits	VA Coventry Bronze Deductible Only HSA Eligible VA Coventry Bronze Deductible Only HSA Eligible Bon Secours VA Coventry Bronze Deductible Only HSA Eligible Southside In network you pay	VA Coventry Bronze $30 Copay In network you pay
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$6,450/$12,900	$6,800/$13,600
Member coinsurance	0%	0%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,450/$12,900	$6,850/$13,700
Primary care visit	Covered in full after ded	$30 copay; ded waived
Specialist visit	Covered in full after ded	$30 copay 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; ded waived	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		
Dental checkup/preventive dental care (2 visits per year)	Not covered	Not covered
Basic dental care	Not covered	Not covered
Major dental care	Not covered	Not covered
Orthodontia (medically necessary only)	Not covered	Not covered
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.

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

Health benefits and health insurance products are underwritten by Coventry Health Care of Virginia, Inc.

VA Coventry Bronze $35 Copay Bon Secours
VA Coventry Bronze $35 Copay Southside

In network you pay	In non-designated you pay
$6,000/$12,000	$6,750/$13,500
0%	0%
$6,850/$13,700	$6,850/$13,700
$35 copay; ded waived	$50 copay after ded
$75 copay after ded	$100 copay after ded
$250 copay per admission after ded	$500 copay per admission after ded
$250 copay after ded	$500 copay after ded
$250 copay after ded	Paid at the designated level
$60 copay after ded	$150 copay after ded
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	Covered in full after ded
Covered in full after ded	$25 copay after ded
$250 copay after ded	$500 copay after ded
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
In network preferred	**In network**
Integrated with medical ded	Integrated with medical ded
Generic: $20 copay after ded	Generic: $25 copay after ded
$50 copay after ded	$60 copay after ded
Generic & Brand: $75 copay after ded	Generic & Brand: $85 copay after ded
P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after ded

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On Exchange Silver Coventry Health Care of Virginia plan options

	VA Coventry Silver $10 Copay	
Member benefits	**In network you pay**	
Ded (ded) individual/family[1] (applies to out-of-pocket maximum)	$3,500/$7,000	
Member coinsurance	30%	
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,500/$13,000	
Primary care visit	$10 copay; ded waived	
Specialist visit	$75 copay; ded waived	
Hospital stay	30% after ded	
Outpatient surgery (ambulatory surgical center/hospital)	30% after ded	
Emergency room (copay waived if admitted)	$500 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	30% after ded	
Diagnostic X-ray	30% after ded	
Imaging (CT/PET scans, MRIs)	30% 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		
Dental checkup/preventive dental care (2 visits per year)	Not covered	
Basic dental care	Not covered	
Major dental care	Not covered	
Orthodontia (medically necessary only)	Not covered	
Pharmacy	**In network preferred**	**In network**
Pharmacy deductible	$500 individual/$1,000 family	$500 individual/$1,000 family
Preferred generic drugs	Low Cost Generic: $5 copay; ded waived Generic: $15 copay; ded waived	Low Cost Generic: $20 copay; ded waived Generic: $20 copay; ded waived
Preferred brand drugs	$40 copay after ded	$50 copay after ded
Nonpreferred drugs	Generic & Brand: $80 copay after ded	Generic & Brand: $90 copay after ded
Specialty drugs*	P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% 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.

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

Health benefits and health insurance products are underwritten by Coventry Health Care of Virginia, Inc.

VA Coventry Silver $10 Copay Bon Secours
VA Coventry Silver $10 Copay Southside

In network you pay	In non-designated you pay
$3,600/$7,200	$5,750/$11,500
20%	40%
$5,500/$11,000	$6,500/$13,000
$10 copay; ded waived	$50 copay after ded
$60 copay; ded waived	$75 copay after ded
20% after ded	40% after ded
20% after ded	40% after ded
$250 copay after ded	Paid at the designated level
$75 copay; ded waived	40% after ded
Covered in full; ded waived	Covered in full; ded waived
Covered in full; ded waived	Covered in full; ded waived
20% after ded	40% after ded
20% after ded	40% after ded
20% after ded	40% after ded
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
In network preferred	**In network**
$500 individual/$1,000 family	$500 individual/$1,000 family
Low Cost Generic: $3 copay; ded waived Generic: $10 copay; ded waived	Low Cost Generic: $15 copay; ded waived Generic: $15 copay; ded waived
$35 copay after ded	$45 copay after ded
Generic & Brand: $80 copay after ded	Generic & Brand: $90 copay after ded
P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after ded

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On Exchange Silver Coventry Health Care of Virginia options (continued)

VA Coventry Silver $10 Copay 2750

Member benefits	In network you pay	
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$2,750/$5,500	
Member coinsurance	40%	
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,850/$13,700	
Primary care visit	$10 copay; ded waived	
Specialist visit	$75 copay; ded waived	
Hospital stay	40% after ded	
Outpatient surgery (ambulatory surgical center/hospital)	40% after ded	
Emergency room (copay waived if admitted)	$500 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	40% after ded	
Diagnostic X-ray	40% after ded	
Imaging (CT/PET scans, MRIs)	40% 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		
Dental checkup/preventive dental care (2 visits per year)	Not covered	
Basic dental care	Not covered	
Major dental care	Not covered	
Orthodontia (medically necessary only)	Not covered	
Pharmacy	**In network preferred**	**In network**
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	Low Cost Generic: $5 copay; ded waived Generic: $15 copay; ded waived	Low Cost Generic: $20 copay; ded waived Generic: $20 copay; ded waived
Preferred brand drugs	$50 copay after ded	$60 copay after ded
Nonpreferred drugs	Generic & Brand: $80 copay after ded	Generic & Brand: $90 copay after ded
Specialty drugs*	P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% 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.

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

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VA Coventry Silver $10 Copay 2750 Bon Secours
VA Coventry Silver $10 Copay 2750 Southside

In network you pay	In non-designated you pay
$2,750/$5,500	$6,250/$12,500
30%	40%
$6,600/$13,200	$6,850/$13,700
$10 copay; ded waived	$50 copay after ded
$65 copay; ded waived	$75 copay after ded
30% after ded	40% after ded
30% after ded	40% after ded
$250 copay after ded	Paid at the designated level
$75 copay; ded waived	40% after ded
Covered in full; ded waived	Covered in full; ded waived
Covered in full; ded waived	Covered in full; ded waived
30% after ded	40% after ded
30% after ded	40% after ded
30% after ded	40% after ded
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
In network preferred	**In network**
Integrated with medical ded	Integrated with medical ded
Low Cost Generic: $5 copay; ded waived Generic: $15 copay; ded waived	Low Cost Generic: $20 copay; ded waived Generic: $20 copay; ded waived
$40 copay after ded	$50 copay after ded
Generic & Brand: $80 copay after ded	Generic & Brand: $90 copay after ded
P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after ded

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On Exchange Gold Coventry Health Care of Virginia plan options

	VA Coventry Gold $10 Copay	
Member benefits	**In network you pay**	
Ded (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)	$5,100/$10,200	
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		
Dental checkup/preventive dental care (2 visits per year)	Not covered	
Basic dental care	Not covered	
Major dental care	Not covered	
Orthodontia (medically necessary only)	Not covered	
Pharmacy	**In network preferred**	**In network**
Pharmacy deductible	$250 individual/$500 family	$250 individual/$500 family
Preferred generic drugs	Low Cost Generic: $3 copay; ded waived Generic: $10 copay; ded waived	Low Cost Generic: $15 copay; ded waived Generic: $15 copay; ded waived
Preferred brand drugs	$35 copay after ded	$45 copay after ded
Nonpreferred drugs	Generic & Brand: $65 copay after ded	Generic & Brand: $80 copay after ded
Specialty drugs*	P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% 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.

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VA Coventry Gold $5 Copay Bon Secours
VA Coventry Gold $5 Copay Southside

In network you pay	In non-designated you pay
$1,250/$2,500	$3,500/$7,000
20%	40%
$4,500/$9,000	$6,000/$12,000
$5 copay; ded waived	$30 copay; ded waived
$40 copay; ded waived	$75 copay after ded
20% after ded	40% after ded
20% after ded	40% after ded
$250 copay after ded	Paid at the designated level
$75 copay; ded waived	$150 copay; ded waived
Covered in full; ded waived	Covered in full; ded waived
Covered in full; ded waived	Covered in full; ded waived
20% after ded	40% after ded
20% after ded	40% after ded
20% after ded	40% after ded
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
In network preferred	**In network**
None	None
Low Cost Generic: $3 copay Generic: $10 copay	Low Cost Generic: $15 copay Generic: $15 copay
$30 copay	$40 copay
Generic & Brand: $65 copay	Generic & Brand: $80 copay
P: 40% NP: 50%	P: 40% NP: 50%

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