

CoventryOne GO Plans

INDIVIDUAL PLAN BENEFITS:	KIGOC05020 20		KIGOC10025 20		KIGOC20040 25		KIGOC25045 25	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime maximum	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Deductible (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
Coinsurance	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
Out-of-pocket maximum (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
Medical benefits shown with copays not subject to deductibles	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
PCP office visit	\$20 Copay	Deductible plus 40%	\$20 Copay	Deductible plus 40%	\$25 Copay	Deductible plus 40%	\$25 Copay	Deductible plus 40%
Specialists office visit	\$35 Copay	Deductible plus 40%	\$35 Copay	Deductible plus 40%	\$40 Copay	Deductible plus 40%	\$40 Copay	Deductible plus 40%
Mammograms	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%
Emergency room services - 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%
Urgent care services	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay
Ambulance - 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%
Inpatient hospital	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
Outpatient hospital / facility (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%
Short term rehabilitation services (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%
Spinal manipulation services - 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%
DME, prosthetics - 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%
Organ transplants - Limited to \$500,000 lifetime benefit maximum	See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits		See Appropriate Benefits	
Home health care	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%
Skilled nursing facility - 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%
Hospice - 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%
Prescription drugs Preferred Generic Only	\$12 copay	See Rx Rider	\$12 copay	See Rx Rider	\$12 copay	See Rx Rider	\$12 copay	See Rx Rider
Mental health and substance abuse (optional benefit) - 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

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 benefit 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.

Benefit limitations are a combination of in-network and out-of-network benefits.

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INDIVIDUAL PLAN BENEFITS:	KIGOC30050 30		KIGOC50075 99		KIGOC500150 99		KIGOF20050 99	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime maximum	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Deductible (per contract year)	\$3,000 Individual \$9,000 Family	\$3,000 Individual \$9,000 Family	\$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
Coinsurance	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Out-of-pocket maximum (per contract year) <small>Includes coinsurance only</small>	\$5,000 Individual \$15,000 Family	\$10,000 Individual \$30,000 Family	\$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
Medical benefits shown with copays not subject to deductibles	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
PCP office visit	\$30 Copay	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Specialists office visit	\$45 Copay	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Mammograms	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 40%	\$0 Copay	Deductible plus 70%
Emergency room services <small>- Copay waived if admitted to hospital</small>	\$150 Copay plus 20%	\$150 Copay plus 20%	\$150 Copay plus 20%	\$150 Copay plus 20%	\$200 Copay plus 20%	\$200 Copay plus 20%	\$125 Copay plus 50%	\$125 Copay plus 50%
Urgent care services	\$100 Copay	\$100 Copay	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 50%	Deductible plus 50%
Ambulance <small>- When medically necessary</small>	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 20%	Deductible plus 50%	Deductible plus 50%
Inpatient hospital	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Outpatient hospital / facility (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 50%	Deductible plus 70%
Short term rehabilitation services (physical, speech and occupational therapies) <small>- Limited to 20 visits per therapy per contract year</small>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
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Home health care	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Skilled nursing facility <small>- Limited to 60 days per contract year</small>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
Hospice <small>- Inpatient limited to 15 days per contract year</small>	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 20%	Deductible plus 40%	Deductible plus 50%	Deductible plus 70%
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Mental health and substance abuse (optional benefit) <small>- Outpatient: limited to 30 visits per contract yr. - Inpatient: limited to 30 days per contract yr.</small>	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits	See Appropriate Benefits

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