



**CAROLINA CARE PLAN**  
A MEDICAL MUTUAL OF OHIO COMPANY

## CAROLINA DIRECT HDHP PLANS

BASE PLAN	1500-100	2000-80	2600-100	2600-80	5000-100
<b>Network Benefit Period Deductible</b> Single/Family	\$1,500/\$3,000	\$2,000/\$4,000	\$2,600/\$5,150	\$2,600/\$5,150	\$5,000/\$10,000
<b>Non-Network Benefit Period Deductible</b> Single/Family	\$1,500/\$3,000	\$2,000/\$4,000	\$2,600/\$5,150	\$2,600/\$5,150	\$5,000/\$10,000
<b>Network Coinsurance Out-of-Pocket Maximum (Including Deductible)</b> Single/Family	\$1,500/\$3,000	\$5,000/\$10,000	\$2,600/\$5,150	\$5,000/\$10,000	\$5,000/\$10,000
<b>Non-Network Coinsurance Out-of-Pocket Maximum (Including Deductible)</b> Single/Family	\$3,000/\$6,000	\$10,000/\$20,000	\$5,200/\$10,300	\$10,000/\$20,000	\$10,000/\$20,000
<b>Coinsurance Network/Non-Network</b>	100% / 60%	80% / 50%	100% / 60%	80% / 50%	100% / 60%
<b>Lifetime Maximum</b>	\$2,000,000				

BENEFITS	NETWORK	NON-NETWORK
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	19 Dependent, 23 Student; Removal at end of month	
<b>Primary Care Physician/Office Services</b>		
Office Visit (Illness/Injury)	Deductible and coinsurance	Deductible and coinsurance
Urgent Care Office Visit	Deductible and coinsurance	
All Immunizations – medically necessary	Deductible and coinsurance	Deductible and coinsurance
<b>Preventive Services-Services covered prior to the deductible, \$300 max per person per benefit period</b>		
Routine Physical Exams	100%	Not Covered
All Immunizations	100%	Not Covered
Routine Vision Exam (One exam per benefit period)	100%	Not Covered
Routine Hearing Exams	100%	Not Covered
Well Child Care Services including Exams, Immunizations & Lab.	100%	Not Covered
Routine Mammogram, Pap Test and PSA tests (Not subject to benefit period max)	100%	Not Covered
Laboratory Test, X-Rays, & Medical Test	100%	Not Covered
<b>Outpatient Services</b>		
Allergy Testing and Treatments	Deductible and coinsurance	Deductible and coinsurance
Specialist Office Visit	Deductible and coinsurance	Deductible and coinsurance
Physical, Occupational & Speech Therapies Cardiac Rehabilitation & Pulmonary Rehabilitation (30 visits or \$1500 combined maximum per benefit period whichever maximum is reached first)	Deductible and coinsurance	Deductible and coinsurance
Chiropractic Services (\$350 max per benefit period)	Not covered	Deductible and coinsurance
Emergency Use of an Emergency Room	Deductible and coinsurance	
Non-Emergency Use of an Emergency Room & Physician	Deductible and coinsurance	
Surgical Services	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Laboratory Test – Preferred Lab	100%	Deductible and coinsurance
Diagnostic Laboratory Test	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Laboratory Test – Genetic Testing (\$5,000 per lifetime maximum)	50% No deductible. Does not accumulate towards the OOP maximum	
Diagnostic Mammogram	Deductible and coinsurance	Deductible and coinsurance
Diagnostic X-Rays & Medical Test	Deductible and coinsurance	Deductible and coinsurance
<b>Inpatient Services</b>		
Semi-Private Room and Board	Deductible and coinsurance	Deductible and coinsurance
Skilled Nursing Facility (60 days per benefit period)	Deductible and coinsurance	Deductible and coinsurance
Physical Medicine/Rehabilitation (\$100,000 per lifetime maximum)	Deductible and coinsurance	Deductible and coinsurance

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BENEFITS	NETWORK	NON-NETWORK	
<b>Additional Services</b>			
Ambulance (\$2,500 max per benefit period)	Deductible and coinsurance		
Dental Services Due to an Accident	Deductible and coinsurance	Deductible and coinsurance	
Diabetic Education & Training	Deductible and coinsurance	Deductible and coinsurance	
Durable Medical Equipment (Surgical Bras limited to 2 per benefit period - \$1,000 max per year)	Deductible and coinsurance	Deductible and coinsurance	
Home Health Care (30 visits per benefit year)	Deductible and coinsurance	Deductible and coinsurance	
Hospice (180 days per lifetime maximum)	Deductible and coinsurance	Not Covered	
Organ and Tissue Transplants (up to schedule amount) *	Deductible and coinsurance	Not Covered	
Private Duty Nursing (\$1,000 max per benefit period)	Deductible and coinsurance	Deductible and coinsurance	
Self-Injectable Specialty Medication	Deductible and coinsurance	Not Covered	
Weight Loss Surgery (\$10,000 per lifetime maximum)	Deductible and coinsurance	Deductible and coinsurance	
Wigs after Chemotherapy Treatments (limited to one wig up to \$250 per lifetime maximum)	Deductible and coinsurance		
<b>Mental Health and Substance Abuse- administered by MHNNet Behavioral Health</b>			
Inpatient Mental Health and Substance Abuse Services (20 days per benefit period)	Deductible and coinsurance	Not Covered	
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	Deductible and coinsurance	Not Covered	
<b>Prescription Drug – Option A</b>			
	Deductible and coinsurance	Not Covered	
<b>Optional Riders</b>			
<b>Maternity Rider</b>			
<b>Eligible expenses incurred during this time of the policy</b>			
Includes routine prenatal, delivery, postnatal care, lab services and inpatient hospitalization. Benefits are payable at a percentage of eligible expenses incurred in a given time period. The period of time is measured from the effective date of the maternity rider.	0 – 12 <sup>th</sup> months 10% of eligible expenses paid	13 <sup>th</sup> – 24 <sup>th</sup> months 50% of eligible expenses paid	25 <sup>th</sup> month and after 100% of eligible expenses paid

*Benefits will be determined based on Carolina Care's medical and administrative policies and procedures. This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Carolina Care may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. In certain instances, Carolina Care's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Carolina Care's negotiated rate with the provider.*

\*The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Carolina Care case manager (except for corneal transplants). Failure to contact the case manager prior to the proposed course of treatment (including the evaluation, reasonable transportation & lodging) will result in a significant monetary penalty. Refer to your certificate for details.