HDHP P Plans

Base Plan Single/Family	P 1500-100 Plan 1 / P 3000-100 Plan 1	P 2000-80 Plan 2 / P 4000-80 Plan 2	P 2600-100 Plan 3 / P 5150-100 Plan 3	P 2600-80 Plan 4 / P 5150-80 Plan 4	P 5000-100 Plan 5 / P 10000-100 Plan 5
Network Benefit Period Deductible Single/Family	$1,500/$3,000	$2,000/$4,000	$2,600/$5,150	$2,600/$5,150	$5,000/$10,000
Non-Network Benefit Period Deductible Single/Family	$1,500/$3,000	$2,000/$4,000	$2,600/$5,150	$2,600/$5,150	$5,000/$10,000
Network Coinsurance Out-of-Pocket Maximum (Including Deductible) Single/Family	$1,500/$3,000	$5,000/$10,000	$2,600/$5,150	$5,000/$10,000	$5,000/$10,000
Non-Network Coinsurance Out-of-Pocket Maximum (Including Deductible) Single/Family	$3,000/$6,000	$10,000/$20,000	$5,200/$10,300	$10,000/$20,000	$10,000/$20,000
Coinsurance Network/Non-Network	100% / 60%	80% / 50%	100% / 60%	80% / 50%	100% / 60%
Overall Annual Benefit Period Maximum	$2,000,000				

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26, Removal upon End of Month	
Primary Care Physician/Office Services		
Office Visit (Illness/Injury)	Deductible and coinsurance	Deductible and coinsurance
Urgent Care Office Visit	Deductible and coinsurance	
Specialist Office Visit	Deductible and coinsurance	Deductible and coinsurance
All Immunizations – medically necessary	Deductible and coinsurance	Deductible and coinsurance
Preventive Services		
Preventive Services, in accordance with state and federal law[1]	100%	Not Covered
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
Outpatient Services		
Allergy Testing and Treatments	Deductible and coinsurance	Deductible and coinsurance
Physical, Occupational & Speech Therapies Cardiac Rehabilitation & Pulmonary Rehabilitation (30 visits combined per benefit period)	Deductible and coinsurance	Deductible and coinsurance
Chiropractic Services (12 visits per benefit period)	Deductible and coinsurance	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	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Laboratory Test	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Laboratory Test – Genetic Testing	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
Inpatient Services		
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	Deductible and coinsurance	Deductible and coinsurance

HDHP P Plans

Benefits	Network	Non-Network
Additional Services		
Ambulance	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)	Deductible and coinsurance	Deductible and coinsurance
Home Health Care (30 visits per benefit period)	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 maximum 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	
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (20 days per benefit period)	Deductible and coinsurance	50% after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	Deductible and coinsurance	50% after deductible
Prescription Drug		
	Deductible and coinsurance	Not Covered

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.

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[1] Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.