



CAROLINA CARE PLAN
A MEDICAL MUTUAL OF OHIO COMPANY

**Synergetic
Point of Service
80/2500/35**

RX BPL #
Medical Plan #

Benefits	Network	Non-Network
Benefit Period (Calendar Year only)	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent / 23 Student Removal upon End of Month	
Pre-Existing Condition Waiting Period	6-12	
Lifetime Maximum	\$5,000,000	
Benefit Period Deductible – Single/Family	\$2,500 / \$5,000	\$3,000 / \$6,000
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$1,000 / \$2,000	\$2,000 / \$4,000
Physician/Office Services		
PCP Office Visit (Illness/Injury) ¹	\$35 co-pay, then 100%	60% after deductible
Specialist Office Visit (Illness/Injury) ¹	\$45 co-pay, then 100%	60% after deductible
Urgent Care Office Visit ¹	\$50 copay, then 100%	
All Immunizations	100%	60% after deductible
Routine Services		
Routine Physical Exams ¹	\$35 co-pay, then 100%	60% after deductible
Well Child Care Services including Exams, Laboratory Tests and Immunizations ¹	\$35 co-pay, then 100%	60% after deductible
Routine Vision Exams ¹	\$35 co-pay, then 100%	60% after deductible
Routine Hearing Exams ¹	\$35 co-pay, then 100%	60% after deductible
Routine Mammogram	100%	60% after deductible
Routine Pap Tests	100%	60% after deductible
Routine Laboratory Test	100%	60% after deductible
Routine Endoscopic Services	80% after deductible	60% after deductible
Routine X-Rays & Medical Test – Facility	80% after deductible	60% after deductible
Routine X-Rays & Medical Test – Professional	80% after deductible	60% after deductible
Outpatient Services		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Laboratory Test – Facility	80% after deductible	60% after deductible
Diagnostic Laboratory Test – Professional	100%	60% after deductible
Diagnostic Laboratory Test – Preferred	100%	60% after deductible
Diagnostic Laboratory Test – Genetic Testing (\$5,000 per lifetime max)	80% after deductible	60% after deductible
Diagnostic Mammogram	100%	60% after deductible
Diagnostic X-Rays & Medical Test – Facility	80% after deductible	60% after deductible
Diagnostic X-Rays & Medical Test – Professional	80% after deductible	60% after deductible
Physical Therapy (60 visits per benefit period)	80% after deductible	60% after deductible
Occupational Therapy (60 visits per benefit period)	80% after deductible	60% after deductible
Chiropractic Therapy (\$350 max per benefit period)	80% after deductible	60% after deductible
Speech Therapy (60 visits per benefit period)	80% after deductible	60% after deductible
Pulmonary Rehabilitation (60 visits per benefit period)	80% after deductible	60% after deductible
Cardiac Rehabilitation (60 visits per benefit period)	80% after deductible	60% after deductible
Emergency Services ²	\$200 co-pay then 100%	
Non – Emergency use of an Emergency Room	80% after deductible	60% after deductible
Prescription Drugs includes Oral Contraceptives & Diabetic Supplies		
Retail 30 day supply	10/20/50	
Mail Order 90 day supply	20/40/125	

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	60% after deductible
Maternity (Employee & Spouse)	Professional Services 100% Facility Services 80% after deductible	60% after deductible
Skilled Nursing Facility (60 days per benefit period)	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	Not Covered
Additional Services		
Outpatient Allergy Testing	80% after deductible	60% after deductible
Allergy Treatments rendered in the Physician's Office	100%	60% after deductible
Ambulance	First \$2500 paid at 80%, thereafter paid at 100% per day. Not subject to deductible. Does not accumulate towards the OOP maximum.	
Dental Services Due to an Accident	80% after deductible	
Diabetic Education & Training ¹	\$35 co-pay, then 100%	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	60% after deductible
Hospice (180 days lifetime)	80% after deductible	Not Covered
Private Duty Nursing	Not Covered	
Therapeutic Injections Self-Injectable Specialty Medication All other Injections	\$75 co-pay, then 100% 100%	60% after deductible
TMJ Services	Not Covered	
Weight Loss Surgical Services including Complications of Weight Loss Surgery	Not Covered	
Wigs after Chemotherapy Treatment (\$250 per lifetime)	100%	
Mental Health & Substance Abuse – administered by MHN Net Behavioral Health. Not subject to deductible. Does not accumulate towards OOP maximum.		
Inpatient Mental Health and Substance Abuse Services (20 days per benefit period)	80%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period) ¹	\$35 co-pay, then 100%	Not Covered

3 month carryover does not apply.

Deductible & Coinsurance expenses incurred for services by a network provider will only apply to the network coinsurance out-of-pocket limits. Deductible & Coinsurance expenses incurred for services by a non-network provider will only apply to the non-network coinsurance out-of-pocket limits.

Benefits will be determined based on Carolina Care Plan'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 Plan 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 Plan'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 Plan'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 Plan 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.

¹All covered services rendered in the doctor's office per day are subject to one co-pay then payable at 100%.

²Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.