

# Group Health Coverage



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



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***Point of Service Plans***

Plan Name	IN-NETWORK					OUT-OF-NETWORK		
	Office Visit Co pay	ER Co pay	Individual Deductible	Coinsurance	Max. Individual OOP	Indiv. Deductible	Coinsurance	Max. Indiv. OOP
100/1500-25	\$25	\$150	\$1,500	100%	N/A	\$3,000	70%	\$6,000
100/2000-25	\$25	\$150	\$2,000	100%	N/A	\$4,000	70%	\$6,000
100/2500-30	\$30	\$200	\$2,500	100%	N/A	\$5,000	70%	\$6,000
100/3500-30	\$30	\$200	\$3,500	100%	N/A	\$7,000	70%	\$6,000
80/500-30	\$30	\$200	\$500	80%	\$2,000	\$1,000	60%	\$6,000
80/750-30	\$30	\$200	\$750	80%	\$2,500	\$1,500	60%	\$6,000
80/1000-30	\$30	\$200	\$1,000	80%	\$3,000	\$2,000	60%	\$6,000
80/1500-30	\$30	\$200	\$1,500	80%	\$3,000	\$3,000	60%	\$6,000
80/1500-35	\$35	\$200	\$1,500	80%	\$4,000	\$3,000	60%	\$9,000
80/2000-35	\$35	\$200	\$2,000	80%	\$4,000	\$4,000	60%	\$9,000
80/2500-35	\$35	\$200	\$2,500	80%	\$4,000	\$5,000	60%	\$9,000
70/1000-35	\$35	\$200	\$1000	70%	\$3000	\$2000	50%	\$6000
70/1500-35	\$35	\$200	\$1500	70%	\$4000	\$3000	50%	\$8000
70/1000-40	\$40	\$200	\$1,000	70%	\$6,000	\$4,000	50%	\$12,000
70/1500-40	\$40	\$200	\$1,500	70%	\$6,000	\$3,000	50%	\$12,000
70/2000-40	\$40	\$200	\$2,000	70%	\$6,000	\$4,000	50%	\$12,000
70/3000-40	\$40	\$200	\$3,000	70%	\$6,000	\$6,000	50%	\$12,000
70/4000-40	\$40	\$200	\$4,000	70%	\$6,000	\$8,000	50%	\$12,000

***Prescription Drug***

Prescription Drug Plan	Tier 1 Generic Drugs	Tier 2 Preferred Brands	Tier 3 Non Preferred Brands	Calendar Year Deductible
A: Standard Formulary	\$8	\$30	\$60	none
B: Standard Formulary plus Deductible	\$8	\$35	\$65	\$100 (waived for generics)

**Value Added Benefits:**

- Expansive office visit copay
- \$5 million lifetime benefit maximum
- No dollar caps on organ transplants
- No dollar caps on preventive services
- 100 percent preferred lab benefit
- 100 percent benefit for physician maternity charges
- No age restriction on immunizations
- Coverage for routine eye care
- COBRA administration services for groups with 20 or more eligible employees

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.



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***HMO Plans***

IN-NETWORK							
Plan Name	Office Visit Co pay PC/Spec.	Preferred Lab	ER Co pay	IP Per Admission Co pay	OP Co pay	Other Services (Deductible/Coinsurance)	Max. Individual OOP
80/500_1500	\$20/\$40	100% coverage	\$200	\$1,500 then 20%	\$500 then 20%	\$500 /80%	\$3,500
80/750_1500	\$20/\$40	100% coverage	\$200	\$1,500 then 20%	\$500 then 20%	\$750/80%	\$3,500
80/1000_2000	\$20/\$40	100% coverage	\$200	\$2,000 then 20%	\$750 then 20%	\$1,000/80%	\$4,000
80/1500_2500	\$20/\$40	100% coverage	\$200	\$2,500 then 20%	\$1,000 then 20%	\$1,500/80%	\$4,500

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***Qualified High Deductible Plans***

IN-NETWORK					OUT-OF-NETWORK		
Plan Name	Deductible	Benefit	Max. OOP (includes deductible)	Rx benefit after Deductible	Deductible	Benefit	Max. OOP (includes deductible)
80/1200 (Single)	\$1,200	80%	\$3,000	80%	\$3,600	50%	\$9,000
80/2400 (Family)	\$2,400	80%	\$6,000	80%	\$7,200	50%	\$22,500
80/1750 (Single)	\$1,750	80%	\$3,000	80%	\$5,250	50%	\$9,000
80/3500 (Family)	\$3,500	80%	\$6,000	80%	\$10,500	50%	\$22,500
80/2500 (Single)	\$2,500	80%	\$5,000	80%	\$7,500	50%	\$15,000
80/5000 (Family)	\$5,000	80%	\$10,000	80%	\$15,000	50%	\$30,000
80/3500 (Single)	\$3,500	80%	\$5,000	80%	\$10,500	50%	\$15,000
80/7000 (Family)	\$7,000	80%	\$10,000	80%	\$21,000	50%	\$30,000
100/2500 (Single)	\$2,500	100%	\$2,500	100%	\$10,000	50%	\$20,000
100/5000 (Family)	\$5,000	100%	\$5,000	100%	\$10,000	50%	\$30,000

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*Vital Access/Enhanced Vital Access*

IN NETWORK									OUT OF NETWORK		
Plan Name	Office Visit Co pay	Preferred Lab	ER Co pay	Imaging and Diagnostic testing	Out Patient Surgical Services	Individual Calendar Year Deductible	Coinsurance After deductible	Max. Individual OOP	Indiv. Deductible	Coinsurance After deductible	Max. Indiv. OOP
Vital Access/ 6,500	\$25/\$75	No deductible 100%	\$200	Subject to deductible	Subject to deductible	\$6,500	100%	N/A	\$15,000	70%	\$7,500
Vital Access/ 7,500	\$25/\$75	No deductible 100%	\$200	Subject to deductible	Subject to deductible	\$7,500	100%	N/A	\$15,000	70%	\$7,500
Enhanced Vital Access/ 7,500	\$25/\$75	No deductible 100%	\$200	First \$500 covered in full then deductible	First \$1,500 covered in full then deductible	\$7,500	100%	N/A	\$15,000	70%	\$7,500
Enhanced Vital Access/ 9,000	\$25/\$75	No deductible 100%	\$200	First \$500 covered in full then deductible	First \$1,500 covered in full then deductible	\$9,000	100%	N/A	\$15,000	70%	\$7,500
Vital Access/ 10,000	\$25/\$75	No deductible 100%	\$200	Subject to deductible	Subject to deductible	\$10,000	100%	N/A	\$15,000	70%	\$7,500
Enhanced Vital Access/ 10,000	\$25/\$75	No deductible 100%	\$200	First \$500 covered in full then deductible	First \$1,500 covered in full then deductible	\$10,000	100%	N/A	\$15,000	70%	\$7,500
Vital Access/ 15,000	\$25/\$75	No deductible 100%	\$200	Subject to deductible	Subject to deductible	\$15,000	100%	N/A	\$20,000	70%	\$7,500
Enhanced Vital Access/ 15,000	\$25/\$75	No deductible 100%	\$200	First \$500 covered in full then deductible	First \$1,500 covered in full then deductible	\$15,000	100%	N/A	\$20,000	70%	\$7,500



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*Prescription Drug*

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