80/20 Plan Benefit Summary

Lifetime Maximum, Deductible, and Out-of-Pocket Limit

Benefit payments are based on where services are received and how services are billed.

	In-Network	***Out-of-Network****
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all *covered services* except where otherwise specifically indicated or excluded. If you exceed any *lifetime maximum,* additional services of that type are not covered. In this case, you may be responsible for the entire amount of the *Provider*'s billed charge.		
Deductible		
Individual, per *benefit period*	$1,250	$2,500
Family, per *benefit period*	$3,750	$7,500
Charges for the following do not apply to the *benefit period deductible*: • *Preventive Care* as defined by the *Affordable Care Act.* • *Copayments.* • *In-Network* services do not apply to the *Out-of-Network deductible*. • *Inpatient* newborn care for well-baby.		
Out-of-Pocket Limit		
Individual, per *benefit period*	$4,890	$9,780
Family, per *benefit period*	$14,670	$29,340
Charges over *allowed amounts* and charges for non-*covered services* do not apply to the *out-of-pocket limit*. The *out-of-pocket limit*, which is the *deductible* plus any copays and *coinsurance* you pay, is the total amount you will pay for *covered services.*		

Preventive Care

	In-Network	***Out-of-Network****
Primary Care Provider	No Charge	Benefits not available[1]
Specialist	No Charge	Benefits not available[1]
Nutrition Counseling	No Charge	**40% after *deductible***
Available in an office-based, *outpatient*, or ambulatory surgical setting, or *urgent care* center. Services include among others: routine physical exams and screenings, well-baby care, well-child care, well-woman care, immunizations, nutritional counseling, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the *Plan's* website at **www.shpnc.org** for the most up-to-date information on *preventive care* covered under federal law.		
[1]The following *preventive care* benefits are available both in- and *out-of-network*: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screenings and prostate specific antigen tests. See *Covered Services*.		

Provider's Office

See *Outpatient Service* for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a combined in- and *out-of-network maximum* of four visits per *benefit period*. Any visits in excess of these *benefit period maximum* are not *covered services*.

***Office Visit* Services**	***In-Network***	***Out-of-Network****
Primary Care Provider	$25 **or $10 copay** when using *PCP* listed on *ID card*	**40% after *deductible***
*Specialist (*includes *Ambulatory Infusion Suite)*	**$80 copay**	**40% after *deductible***
Includes office *surgery,* X-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see *Outpatient Diagnostic Services.*		

CT Scans, MRIs, MRAs, and PET Scans	20% after *deductible*	40% after *deductible*

Short-Term Therapy Services (Includes Evaluation and Management)

Limited to rehabilitative and habilitative speech, physical, and *occupational* therapy.

	In-Network	***Out-of-Network****
Short-Term Rehabilitative Therapies	$52 *copayment*	40% after *deductible*
Short-Term Rehabilitative Therapies include chiropractic care**,** occupational therapy, and physical therapy. Combined in- and *out-of-network* benefit maximums apply to chiropractic services only. There is a 30-visit limit for Chiropractic care. Any visits in excess of this *benefit period maximum* are not *covered services*.		
Other Therapies	No Charge	40% after *deductible*
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient Services* for *other therapies* provided in an *outpatient* setting.		
***Infertility* and *Sexual Dysfunction* Services**		
Primary Care Provider	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	40% after *deductible*
Specialist	**$80 *copay***	40% after *deductible*
Combined in- and out-of-network lifetime limit of 3 ovulation induction cycles and associated services without insemination. Any services in excess of this lifetime limit are not *covered services*.		
Routine Hearing Evaluation Tests		
Primary Care Provider	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	**Benefits not available**
Specialist	**$80 *copay***	**Benefits not available**

Urgent Care Centers, Emergency Rooms, and Ambulance Services

	In-Network	***Out-of-Network****
Urgent Care Centers	$70 *copayment*	$70 *copayment*
***Emergency Room* Visit**	$300 *copayment,* then 20% after *deductible*	$300 *copayment,* then 20% after *deductible*
Emergency Room Copayment is waived if admitted or held for observation at the *hospital*. If admitted to the *hospital* from the *emergency room*, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the *emergency* room from an *Urgent Care Center*, you may be responsible for both the *emergency* room *copayment* and the *urgent care copayment*.		
***Ambulance* Services**	20% after *deductible*	20% after *deductible*

Ambulatory Surgical Centers

	In-Network	***Out-of-Network****
Ambulatory Surgical Services	20% after *deductible*	40% after *deductible*

Outpatient Services

	In-Network	***Out-of-Network****
***Provider* Services**	20% after *deductible*	40% after *deductible*
***Hospital* and *Hospital Based* Services**	20% after *deductible*	40% after *deductible*

***Outpatient Clinical* Services**	20% after *deductible*	40% after *deductible*
***Outpatient* Diagnostic Services**		
***Outpatient* lab tests, when performed alone (physician and *hospital*-based services)**	No Charge	40% after *deductible*
***Outpatient* lab tests, when performed with another service**		
Physician Services	No Charge	40% after *deductible*
Hospital and *Hospital*-based Services	20% after *deductible*	40% after *deductible*
***Outpatient* x-rays, ultrasounds, and other diagnostic test, such as EEGs, EKGs and pulmonary function tests**	20% after *deductible*	40% after *deductible*
CT scans, MRIs, MRAs, and PET scans	20% after *deductible*	40% after *deductible*
***Outpatient* diagnostic mammography (physician and *hospital*-based services)**	No Charge	40% after *deductible*
See "Preventive Care" for coverage of screening mammograms.		
Therapy Services Includes *short-term rehabilitative therapies* and *other therapies*.	20% after *deductible*	40% after *deductible*

Inpatient Hospital Services

	In-Network	***Out-of-Network****
***Provider* Services**	20% after *deductible*	40% after *deductible*
***Hospital* and *Hospital Based* Services**	$300 *copayment,* then 20% after *deductible*/coinsurance	$300 *copayment,* then 40% after *deductible*
Includes maternity delivery, prenatal and post-delivery care. For *inpatient* mental health and *substance abuse* services, refer to the "Mental Health and *Substance Abuse Services*" section later in this summary. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period,* you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers.*		

Nursing

	In-Network	***Out-of-Network****
Skilled Nursing Facility	20% after *deductible*	40% after *deductible*
Combined *in-* and *out-of-network maximum* of 100 days per *benefit period*. Services applied to the *deductible* count towards the day maximum. Any services in excess of this *benefit period maximum* are not *covered services*.		
Private Duty Nursing	20% after *deductible*	40% after *deductible*
There is a 4 hour per day limit on private duty nursing care for non-ventilated patients and 12 hours per day limit on private duty nursing for ventilated patients.		
Other Services	20% after *deductible*	40% after *deductible*

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Includes *durable medical equipment*, *hospice* services, *medical supplies*, orthotic devices, private duty nursing, *prosthetic appliances*, and *home health care*. Orthotic devices for correction of *positional plagiocephaly* are limited to one per lifetime. Hearing aids are limited to one per hearing-impaired ear every 36 months for *members* under the age of 22. Any services in excess of these *benefit period* or *lifetime maximums* are not *covered services*.

Mental Health / Substance Abuse Services

	In-Network	***Out-of-Network****
Mental Health / *Substance Abuse* *Office Services*	$25 *copayment*	40%
Mental Health / *Substance Abuse* *Outpatient* Services	20% after *deductible*	40% after *deductible*
Mental Health / *Substance Abuse* *Inpatient* Services**	$300 *copayment*, then 20% after *deductible*	$300 *copayment*, then 40% after *deductible*
Residential Treatment Centers*** Covered up to age 18.	$300 *copayment*, then 20% after *deductible*	$300 *copayment*, then 40% after *deductible*

No age limit for *Substance Abuse*.
**Requires *certification* within two business days of admission.
***Requires *certification* and *prior review* in advance by the *Mental Health Case Manager and* must be an approved residential treatment center.
Failure to request *prior review* and receive *certification* will result in full denial of benefits. *Certification* is not a guarantee of payment. See "*Covered Services*" and "Prospective Review/*Prior Review*" in "*Utilization Management.*"

Prescription Medications

Prescription medication benefits are administered by CVS Caremark (the Pharmacy Benefits Manager – *PBM*). See "*Prescription Medication Copayment and Benefits*" in "*Covered Services*" for more information.

	0-30 Day Supply	**31-60 Day Supply**	**61-90 Day Supply**
Tier 1	$5	$10	$15
Tier 2	$30	$60	$90
Tier 3	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*
Tier 4	$100	$200	$300
Tier 5	$250	$500	$750
Tier 6	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*
Affordable Care Act Preventive Medications	Covered at 100%		

A list of *Affordable Care Act Preventive Medications* is on the *Plan's* website at **www.shpnc.org**.

NOTE: All *specialty medication* covered under the pharmacy benefit, excluding cancer medications, must be obtained through CVS Caremark Specialty Pharmacy.

Diabetic Testing Supplies

Diabetic testing supplies are covered under your medical and pharmacy benefit. Under your pharmacy benefit, for a single *copayment*, insulin dependent *members* may receive up to 204 test strips (depending on manufacturer's packaging) and non-insulin dependent *members* may receive 102 test strips (depending on manufacturer's packaging) per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to *deductible* and *coinsurance*.

	0-30 Day Supply	31-60 Day Supply	61-90 Day Supply
Preferred Brand Testing Supplies	$5	$10	$15
Non-Preferred Brand Testing Supplies	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*
For *certification* for certain *prescription medications*, your physician may call CVS Caremark at 800-294-5979 to initiate a *certification* request.			

***Certification* Requirements**

*In-network provider*s outside of North Carolina, except for Veterans Affairs (VA) and military *provider*s, are responsible for requesting *prior review* for *inpatient facility services*. For all other *covered services* received outside of North Carolina, you are responsible for ensuring that you or your *provider* requests *prior review* by the *State Health Plan* even if you see an *in-network provider*.

Certain services, regardless of the location, require *prior review* and *certification* in order to receive benefits. If you go to an *in-network provider* in North Carolina, your *provider* will request *prior review* when necessary. If you go to an *out-of-network provider* in North Carolina or to any *provider* outside of North Carolina, you are responsible for requesting or ensuring that your *provider* requests *prior review*. Failure to request *prior review* and receive *certification* will result in full denial of benefits. See "*Covered Services*" and "*Prior review* (pre-service)" in "*Utilization Management*."

The *Plan* delegates administration of your mental health and *substance abuse* benefits to the *Plan's Mental Health Case Manager*. *Prior review* and *certification* by the *Plan's Mental Health Case Manager* are required for *inpatient* and certain *outpatient* mental health and *substance abuse* services received from an *in-network provider*, except for *emergencies*. Please see the number in "Who to Contact."

For *certification* for certain *prescription medications*, your physician may call CVS Caremark at 800-294-5979 to initiate a *certification* request.

NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *deductible* and *coinsurance* amount.

Obesity Treatment/ Weight Management

	In-Network	***Out-of-Network***
Primary Care Provider	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	40% after *deductible*
Specialist	**$80 *copay***	40% after *deductible*
***Outpatient* Physician Services**	20% after *deductible*	40% after *deductible*
***Outpatient Hospital* and *Hospital*-based Services**	20% after *deductible*	40% after *deductible*
***Inpatient* Physician Services**	20% after *deductible*	40% after *deductible*
***Inpatient Hospital* and *Hospital*-based Services**	20% after *deductible*	40% after *deductible*
Offices visits for the evaluation and treatment of obesity are limited to a combined *in*-and *out-of-network* maximum for four visits per *benefit period.* Any visits in excess of these *benefit period maximums* are not *covered services.*		