High Deductible Health 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*	$5,000	$10,000
Family, per *benefit period*	$10,000	$20,000
Charges for the following do not apply to the *benefit period deductible*: • *Preventive Care* as defined by the *Affordable Care Act.* • *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*	$6,450	$12,900
Family, per *benefit period*	$12,900	$25,800
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 *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	60% after deductible
Specialist	No Charge	60% after deductible
Nutrition Counseling	No Charge	60% 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.		
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	50% after deductible	**60% after *deductible***
*Specialist (*includes *Ambulatory Infusion Suite)*	50% after deductible	**60% 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	50% after deductible	60% 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	50% after deductible	60% 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	50% after deductible	60% 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	50% after deductible	60% after *deductible*
Specialist	50% after deductible	60% 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	50% after deductible	**Benefits not available**
Specialist	50% after deductible	**Benefits not available**

Urgent Care Centers, Emergency Rooms, and Ambulance Services

	In-Network	***Out-of-Network****
Urgent Care Centers	50% after deductible	60% after deductible
***Emergency Room* Visit**	50% after deductible	60% after deductible
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 *charges* and the *urgent care charges*.		
***Ambulance* Services**	50% after deductible	60% after deductible

Ambulatory Surgical Centers

	In-Network	***Out-of-Network****
Ambulatory Surgical Services	50% after deductible	60% after *deductible*

Outpatient Services

	In-Network	***Out-of-Network****
***Provider* Services**	50% after deductible	60% after *deductible*
***Hospital* and *Hospital Based* Services**	50% after deductible	60% after *deductible*
***Outpatient Clinical* Services**	50% after deductible	60% after *deductible*
***Outpatient* Diagnostic Services**		

***Outpatient* lab tests, when performed alone (physician and *hospital*-based services)**	No Charge	60% after *deductible*
***Outpatient* lab tests, when performed with another service**		
Physician Services	No Charge	60% after *deductible*
Hospital and *Hospital*-based Services	50% after deductible	60% after *deductible*
***Outpatient* x-rays, ultrasounds, and other diagnostic test, such as EEGs, EKGs and pulmonary function tests**	50% after deductible	60% after *deductible*
CT scans, MRIs, MRAs, and PET scans	50% after deductible	60% after *deductible*
***Outpatient* diagnostic mammography (physician and *hospital*-based services)**	50% after deductible	60% after *deductible*
See "Preventive Care" for coverage of screening mammograms.		
Therapy Services Includes *short-term rehabilitative therapies* and *other therapies*.	50% after deductible	60% after *deductible*

Inpatient Hospital Services

	In-Network	***Out-of-Network****
***Provider* Services**	50% after deductible	60% after *deductible*
***Hospital* and *Hospital Based* Services**	50% after deductible	60% 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	50% after deductible	60% 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	50% after deductible	60% 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	50% after deductible	60% after *deductible*
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 *member*s 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*	50% after deductible	60% after deductible
Mental Health / *Substance Abuse Outpatient* Services	50% after deductible	60% after *deductible*
Mental Health / *Substance Abuse Inpatient* Services**	50% after deductible	60% after deductible
Residential Treatment Centers*** Covered up to age 18.	50% after deductible	60% 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 and Benefits*" in "*Covered Services*" for more information.

Prescription Drugs (Generic, Brand-Name, and Specialty Drugs) **Diabetic Supplies**	50% 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.

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 providers outside of North Carolina, except for Veterans Affairs (VA) and military *providers*, 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	50% after deductible	60% after *deductible*
Specialist	50% after deductible	60% after *deductible*
***Outpatient* Physician Services**	50% after deductible	60% after *deductible*
***Outpatient Hospital* and *Hospital*-based Services**	50% after deductible	60% after *deductible*
***Inpatient* Physician Services**	50% after deductible	60% after *deductible*
***Inpatient Hospital* and *Hospital*-based Services**	50% after deductible	60% 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.*		