

The following summary is included **for informational purposes only**.

## The State Health Plan for Teachers and State Employees Plan Comparisons

Plan Design Feature	Basic (70/30)		Standard (80/20)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Benefit Year Deductible</b>	<b>\$800</b> Individual <b>\$2,400</b> Family	<b>\$1,600</b> Individual <b>\$4,800</b> Family	<b>\$600</b> Individual <b>\$1,800</b> Family	<b>\$1,200</b> Individual <b>\$3,600</b> Family
<b>Plan Coinsurance</b>	30% of eligible expenses after deductible	50% of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>	20% of eligible expenses after deductible	40% of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>
<b>Coinsurance Maximum (does not include deductible)</b>	<b>\$3,250</b> Individual <b>\$9,750</b> Family	<b>\$6,500</b> Individual <b>\$19,500</b> Family	<b>\$2,750</b> Individual <b>\$8,250</b> Family	<b>\$5,500</b> Individual <b>\$16,500</b> Family
<b>Office Visits</b>	<b>\$30</b> <sup>1</sup> copay primary care <b>\$70</b> <sup>1</sup> copay specialist	50% coinsurance after deductible	<b>\$25</b> <sup>1</sup> copay primary care <b>\$60</b> <sup>1</sup> copay specialist	40% coinsurance after deductible
<b>Urgent Care</b>	<b>\$75</b> copay	Same as in-network benefit	<b>\$75</b> copay	Same as in-network benefit
<b>Emergency Room</b>	<b>\$250</b> copay plus 30% coinsurance after deductible	Same as in-network benefit	<b>\$200</b> copay plus 20% coinsurance after deductible	Same as in-network benefit
<b>Inpatient</b>	<b>\$250</b> copay plus 30% coinsurance after deductible	<b>\$250</b> copay then 50% coinsurance after deductible	<b>\$200</b> copay plus 20% coinsurance after deductible	<b>\$200</b> copay then 40% coinsurance after deductible
<b>Outpatient Hospital and Ambulatory Surgical Center</b>	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Preventive Care</b>	<b>\$30</b> <sup>1</sup> copay primary care <b>\$70</b> <sup>1</sup> copay specialist	Not covered <sup>2</sup>	<b>\$25</b> <sup>1</sup> copay primary care <b>\$60</b> <sup>1</sup> copay specialist	Not covered <sup>2</sup>
<b>Short-Term Rehabilitative Therapies</b>				
<b>Evaluation and Management</b>	<b>\$30</b> copay primary care <b>\$70</b> copay specialist	50% after deductible 50% after deductible	<b>\$25</b> copay primary care <b>\$60</b> copay specialist	40% after deductible 40% after deductible
<b>Therapy Services</b>	<b>\$55</b> copay	50% after deductible	<b>\$45</b> copay	40% after deductible
Limited to rehabilitative physical therapy, occupational therapy, and speech therapy (PT/OT/ST)				
<b>Chiropractic (Chiro)</b>	<b>\$55</b> <sup>1</sup> copay – 30 visit limit per benefit period	50% coinsurance after deductible	<b>\$45</b> <sup>1</sup> copay – 30 visit limit per benefit period	40% coinsurance after deductible
<b>Mental Health/ Substance Abuse (MH/SA) Office Services</b>	<b>\$55</b> <sup>1</sup> copay	50% coinsurance	<b>\$45</b> <sup>1</sup> copay	40% coinsurance
<b>Outpatient Services</b>	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Inpatient Services</b>	<b>\$250</b> copay then 30% coinsurance after deductible	<b>\$250</b> copay then 50% coinsurance after deductible	<b>\$200</b> copay then 20% coinsurance after deductible	<b>\$200</b> copay then 40% coinsurance after deductible
	Prior authorization is required after 26-combined in and out-of-network office visits		Prior authorization is required after 26-combined in and out-of-network office visits	
<b>Generic Rx</b>	<b>\$10</b> copay for 30 day supply		<b>\$10</b> copay for 30 day supply	
<b>Preferred Brand Rx (no generic equivalent)</b>	<b>\$35</b> copay for 30 day supply		<b>\$35</b> copay for 30 day supply	
<b>Non-Preferred Brand Rx (no generic equivalent)</b>	<b>\$55</b> copay for 30 day supply		<b>\$55</b> copay for 30 day supply	

For brand name drugs with an available generic, members will be required to pay the generic copay, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug.

<b>Specialty Rx</b> <sup>3</sup>	<b>25%</b> coinsurance up to <b>\$100</b> for <b>each 30 day supply</b>	<b>25%</b> coinsurance up to <b>\$100</b> for <b>each 30 day supply</b>
<b>Diabetic Supplies</b> <sup>4</sup>	<b>\$10</b> copay for preferred brand for <b>30 day supply</b> <b>\$25</b> copay for non-preferred brand for <b>30 day supply</b>	<b>\$10</b> copay for preferred brand for <b>30 day supply</b> <b>\$25</b> copay for non-preferred brand for <b>30 day supply</b>

- In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to determine if your physician's practice is hospital owned or operated.
- The following preventive care benefits are available both in and out-of-network; gynecological exams, cervical cancer screenings, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen tests.
- All non-acute specialty drugs, excluding cancer medications, must be obtained through the Accredo specialty pharmacy.
- For a single copay, insulin dependent members will receive 153 test strips and non-insulin dependent members receive 51 test strips per 30 day supply. Additional test strips needed are covered under the medical supply benefit.

**All benefits are subject to medical necessity. Amounts shown reflect what the members pay.**

**Please visit the State Health Plan website at <http://shpnc.org> or contact:  
Customer Service at 1-888-234-2416 for a plan booklet**