

State Health Plan: 85/15 Consumer-Directed Health Plan Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual, Individual + Spouse,

Individual + Children, Family | Plan Type: High Deductible PPO with HRA



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://www.shpnc.org> or by calling 855-859-0966.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,500 person / \$4,500 family for in-network; \$3,000 person / \$9,000 family for out-of-network; doesn't apply to in-network preventive care or CDHP Preventive Medications.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$3,500 person / \$10,500 family for in-network; \$7,000 Person / \$21,000 family for out-of-	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Your cost for services when pre-authorization was not obtained; premiums, balance-billed charges and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on a later page. See your policy or plan document for additional information about <u>excluded services</u> .
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- **Copayments** are fixed dollar amounts (for example, \$35) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 15% would be \$150. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance**

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	15% coinsurance; \$25 added to your HRA if you use Primary Care Provider on ID card.	35% coinsurance	_____none_____
	Specialist visit	15% coinsurance; \$20 added to your HRA if a Blue Options Designated provider is utilized.	35% coinsurance	_____none_____
	Other practitioner office visit	15% coinsurance	35% coinsurance	Coverage is limited to a combined 30 visits per benefit period for chiropractic care, physical therapy and occupational therapy and 30 visits per benefit period for speech therapy.

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		In-Network Provider	Out-of-Network Provider	
	Preventive care/screening / immunization	\$0/visit	Not covered, except for mandated coverage	The deductible does not apply.
If you have a test	Diagnostic test (X-ray, blood work)	15% coinsurance; 0% coinsurance for lab work.	35% coinsurance	No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Prior authorization may be required or services will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.shpnc.org	Prescription drugs	15% coinsurance	35% coinsurance	Per 30-day supply.
	Affordable Care Act Preventive Medications	0% coinsurance; no deductible	0% coinsurance; no deductible	Prescription must be written and filled at the pharmacy counter. The deductible does not apply.
	CDHP Preventive Medication	15% coinsurance; no deductible	35% coinsurance; no deductible	Prescription must be written and filled at the pharmacy counter. The deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	—————none—————
	Physician/surgeon fees	15% coinsurance	35% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	—————none—————
	Emergency medical transportation	15% coinsurance	15% coinsurance	—————none—————
	Urgent care	15% coinsurance	15% coinsurance	—————none—————

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		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance / admission; \$200 added to your HRA if a Blue Options Designated facility is utilized.	35% coinsurance	Precertification required.
	Physician/surgeon fee	15% coinsurance	35% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	35% coinsurance	Precertification may be required.
	Mental/Behavioral health inpatient services	15% coinsurance / admission; \$200 added to your HRA if a Blue Options Designated facility is	35% coinsurance	Precertification required.
	Substance use disorder outpatient services	15% coinsurance	35% coinsurance	Precertification may be required.
	Substance use disorder inpatient services	15% coinsurance / admission; \$200 added to your HRA if a Blue Options Designated facility is utilized.	35% coinsurance	Precertification required.
Common Medical	Services You May Need	Your cost if you use an		Limitations & Exceptions

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Event		In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	15% coinsurance	35% coinsurance	—————none—————
	Delivery and all inpatient services	15% coinsurance / admission; \$200 added to your HRA if a Blue Options Designated facility is utilized.	35% coinsurance	—————none—————
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	Prior authorization required or services will not be covered.
	Rehabilitation services	15% coinsurance	35% coinsurance	—————none—————
	Habilitation services	Not covered	Not covered	Excluded
	Skilled nursing care	15% coinsurance	35% coinsurance	Coverage is limited to 100 visits per benefit period. Precertification required.
	Durable medical equipment	15% coinsurance	35% coinsurance	Prior authorization may be required for benefits to be provided.
	Hospice services	15% coinsurance	35% coinsurance	Precertification may be required
If your child needs dental or eye care	Eye exam	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	Excluded
	Dental check-up	Not covered	Not covered	Excluded

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Eye exams (Child)
- Glasses
- Habilitation services
- Hearing aids (age 22 and older)
- Hospital inpatient precertification required
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (up to 30 visits per benefit period)
- Hearing aids (under age 22)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bluecardworldwide.com
- Private Duty Nursing

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-859-0966. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: State Health Plan Customer Service at 1-888-234-2416 or shpnc.org. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable. You may also contact North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or 919-807-6750 (in North Carolina), 800-546-5664 (outside North Carolina), if applicable.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shiká'adoowoł nínzingo kwoji' hólné', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

-----*To see examples how this plan might cover costs for a sample medical situation, see the next page*-----

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About these Coverage

Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$5,030
- **You pay** \$2,510

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$860
Limits or exclusions	\$150
Total	\$2,510

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-234-2416.

Managing type 2 diabetes
(routine maintenance of well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,300
- **You pay** \$2,100

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$170
Limits or exclusions	\$430
Total	\$2,100

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Questions and Answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You cannot use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you will pay in out-of-pocket costs, such as **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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