



Employee Contributions for Health Care Benefits

	Smart Choice Basic (PPO 70/30)		Smart Choice Standard (PPO 80/20)	
	Monthly Rate	Biweekly Deduction	Monthly Rate	Biweekly Deduction
30 to 40 Hour Employees				
Employee only	\$0.00	\$0.00	\$ 0.00	\$0.00
Employee + Child/Children	\$164.08	\$82.04	\$218.20	\$109.10
Employee + Spouse	\$422.74	\$211.37	\$502.74	\$251.37
Family	\$450.26	\$225.13	\$533.00	\$266.50
20 to 29 Hour Employees				
Employee only	\$377.22	\$188.61	\$377.22	\$188.61
Employee + Child/Children	\$541.30	\$270.65	\$595.42	\$297.71
Employee + Spouse	\$799.96	\$399.98	\$879.96	\$439.98
Family	\$827.48	\$413.74	\$910.22	\$455.11

PPO Plan Customer Service: 1-888-234-2416

Additional information can be obtained on the Web at www.SHPNC.org or www.UNCHCSBenefits.com



North Carolina State Health Plan - Benefit Changes for 2009 -2010¹

	Basic Plan 70/30				Standard Plan 80/20			
Plan Design Feature	2007-2009		2009-2010		2007-2009		2009-2010	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual Family	\$600 \$1,800	\$1,200 \$3,600	\$800 \$2,400	\$1,600 \$4,800	\$300 \$900	\$600 \$1,800	\$600 \$1,800	\$1,200 \$3,600
Coinsurance Max. Individual Family	\$2,500 \$7,500	\$5,000 \$15,000	\$3,250 \$9,750	\$6,500 \$19,500	\$1,750 \$5,250	\$3,500 \$10,500	\$2,750 \$8,250	\$5,500 \$16,500
Urgent Care Copay	\$75		\$75		\$50		\$75	
Primary Copay	\$25	50% coinsurance after deductible	\$30	50% coinsurance after deductible	\$20	40% coinsurance after deductible	\$25	40% coinsurance after deductible
Specialist Copay	\$50	50% coinsurance after deductible	\$70	50% coinsurance after deductible	\$40	40% coinsurance after deductible	\$60	40% coinsurance after deductible
Physical Therapy/ Occupational/Speech	\$25 primary \$50 specialist	50% coinsurance after deductible	\$55	50% coinsurance after deductible	\$20 primary \$40 specialist	40% coinsurance after deductible	\$45	40% coinsurance after deductible
Chiropractic	\$50 specialist	50% coinsurance after deductible	\$55	50% coinsurance after deductible	\$40 specialist	40% coinsurance after deductible	\$45	40% coinsurance after deductible
Mental Health / Chemical Dependency Office Services	\$50 specialist	50% coinsurance	\$55	50% coinsurance	\$40 specialist	40% coinsurance	\$45	40% coinsurance
Routine Eye Exam²	\$25	Not covered	\$30	Not covered	\$20	Not covered	\$25	Not covered
Inpatient Copay	\$200	\$200	\$250	\$250	\$150	\$150	\$200	\$200
Generic Rx Copay	\$10		\$10		\$10		\$10	
Brand Rx Copay (no generic equivalent)	\$30		\$35		\$30		\$35	
Non-Preferred Brand Rx Copay	\$50		\$55		\$50		\$55	
Brand Rx Copay (generic equivalent available)	\$40		This copay tier has been eliminated. Member will be required to pay the difference between the Plan's actual cost of the brand name drug and the amount the Plan would have paid for the generic equivalent in addition to the generic copay.		\$40		This copay tier has been eliminated. Member will be required to pay the difference between the Plan's actual cost of the brand name drug and the amount the Plan would have paid for the generic equivalent in addition to the generic copay.	
Specialty Rx³	Various		25% coinsurance up to \$100 for each 30 day supply		Various		25% coinsurance up to \$100 for each 30 day supply	
Diabetic Supplies	\$10 for preferred brand \$25 for non-preferred brand		\$10 for preferred brand \$25 for non-preferred brand		\$10 for preferred brand \$25 for non-preferred brand		\$10 for preferred brand \$25 for non-preferred brand	
Pharmacy Benefit Days Supply	34		30		34		30	