2025 STATE HEALTH PLAN COMPARISON

Active and Non-Medicare Subscribers

PLAN DESIGN FEATURES	Enhanced PPO Plan (80/20)		Base PPO Plan (70/30)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,250 Individual $3,750 Family	$2,500 Individual $7,500 Family	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Coinsurance	20% of eligible expenses after deductible is met	40% of eligible expenses after deductible is met and the difference between the allowed amount and the charge	30% of eligible expenses after deductible is met	50% of eligible expenses after deductible is met and the difference between the allowed amount and the charge
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	$4,890 Individual $14,670 Family	$9,780 Individual $29,340 Family	$5,900 Individual $16,300 Family	$11,800 Individual $32,600 Family
Preventive Services	$0 (covered by the Plan at 100%)	N/A	$0 (covered by the Plan at 100%)	N/A
Office Visits	$0 for CPP PCP on ID card; $10 for non-CPP PCP on ID card; $25 for any other PCP	40% after deductible is met	$0 for CPP PCP on ID card; $30 for non-CPP PCP on ID card; $45 for any other PCP	50% after deductible is met
Teladoc	$25		$45	
Specialist Visits	$40 for CPP Specialist; $80 for other Specialists	40% after deductible is met	$47 for CPP Specialist; $94 for other Specialists	50% after deductible is met
Speech, Occupational, Chiropractic and Physical Therapy	$26 for CPP Provider; $52 for other Providers	40% after deductible is met	$36 for CPP Provider; $72 for other Providers	50% after deductible is met
Urgent Care	$70		$100	

PCP: Primary Care Provider, CPP: Clear Pricing Project

To find a CPP Provider, visit **www.shpnc.org** and click Find a Doctor.

PLAN DESIGN FEATURES	Enhanced PPO Plan (80/20)		Base PPO Plan (70/30)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Copay waived with admission or observation stay)	$300 copay, then 20% after deductible is met		$337 copay, then 30% after deductible is met	
Inpatient Hospital	$300 copay, then 20% after deductible is met	$300 copay, then 40% after deductible is met	$337 copay, then 30% after deductible is met	$337 copay, then 50% after deductible is met
PHARMACY BENEFITS				
Tier 1	$5 copay per 30-day supply		$16 copay per 30-day supply	
Tier 2	$30 copay per 30-day supply		$47 copay per 30-day supply	
Tier 3	Deductible/coinsurance		Deductible/coinsurance	
Tier 4	$100 copay per 30-day supply		$200 copay per 30-day supply	
Tier 5	$250 copay per 30-day supply		$350 copay per 30-day supply	
Tier 6	Deductible/coinsurance		Deductible/coinsurance	
Preferred Blood Glucose Meters (BGM) and Supplies*	$5 copay per 30-day supply		$10 copay per 30-day supply	
Preferred and Non-Preferred Insulin	$0 copay per 30-day supply		$0 copay per 30-day supply	
Preventive Medications	$0 (covered by the Plan at 100%)		$0 (covered by the Plan at 100%)	

*This does not include Continuous Glucose Monitoring Systems or associated supplies. These are considered a Tier 2 member copay.