



Cherokee County: POS Plan Employee Benefit Plan

Coverage for: Individual, Individual + Spouse, Individual + Child(ren), Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myLuminareHealth.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-990-9058 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred provider : \$750 / individual or \$2,250 / family per calendar year. Nonpreferred provider : \$6,000 / individual or \$18,000 / family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. True medical emergency services, ambulance services, hospice care, nonpreferred provider preventive care for children under age 6, and the following preferred provider services: office services, urgent care centers, therapy services; preventive care and prescription drug coverage are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred provider : \$2,000 / individual or \$6,000 / family per calendar year. Nonpreferred provider : \$9,000 / individual or \$27,000 / family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myLuminareHealth.com or call 1-800-990-9058 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay /office visit deductible does not apply	40% coinsurance	None
	Specialist visit	\$30 copay /office visit deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No charge	Birth thru age 5: 40% coinsurance deductible does not apply; Age 6 and over: 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office lab tests no charge; Office x-rays \$25/\$30 copay /visit deductible does not apply; Other 20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.us-rxcare.com or call 1-877-200-5533.	Tier 1	Retail \$10 copay / prescription deductible does not apply & Mail order \$25 copay / prescription deductible does not apply	Not Covered	Copay applies to a 30-day supply Retail and Specialty drugs or 90-day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. Not all prescription drugs are covered.
	Tier 2	Retail \$35 copay / prescription deductible does not apply & Mail order \$50 copay / prescription deductible does not apply	Not Covered	
	Tier 3	Retail \$80 copay / prescription deductible does not apply & Mail order \$50 copay / prescription deductible does not apply	Not Covered	
	Tier 4/ Specialty drugs	20% coinsurance up to a maximum of \$200 copay / prescription deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for some procedures. If you don't get preauthorization , benefits could be reduced.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$250 copay deductible does not apply	Preferred provider benefit applies.	Copay waived if admitted.
	Emergency medical transportation	No charge	Preferred provider benefit applies.	Must be medically necessary.
	Urgent care	\$30 copay /visit deductible does not apply	Preferred provider benefit applies.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay , then 20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /visit deductible does not apply	40% coinsurance	None
	Inpatient services	Facility \$500 copay , then 20% coinsurance ; Professional 0% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
If you are pregnant	Office visits	\$25/\$30 copay /visit deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	\$500 copay , then 20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	120 visits/calendar year. Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Rehabilitation services	Respiratory, radiation and chemotherapy: No charge; Other therapies: \$25 copay /visit deductible does not apply	40% coinsurance	20 visits/calendar year combined for physical and occupational therapy. 20 visits/calendar year for speech therapy. 30 visits/calendar year for respiratory therapy.
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	0% coinsurance	40% coinsurance	30 visits/calendar year. Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myLuminareHealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Children's glasses	Not covered	Not covered	No coverage for glasses under medical.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery	• Dental care • Infertility treatment • Long-term care • Private-duty nursing	• Routine eye care • Routine foot care • Weight loss treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Hearing aids for children through age 18, limited to \$3,000 per ear every 48 months	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Contact Luminare Health Benefits, Inc. at 1-800-990-9058 or visit us at www.myLuminareHealth.com.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-990-9058.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-990-9058.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-990-9058.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-990-9058 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-990-9058.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-990-9058.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-990-9058.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-990-9058.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$800

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$2,060
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$800
Coinsurance	\$10

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,580
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$750
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$400
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$800
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.