Benefit Summary
for
Cherokee County

Medical and Prescription Drug Benefits
Dental Benefits

Effective 07/01/2018

CRESCENT
HEALTH SOLUTIONS

Introduction

Cherokee County, NC (the "Employer" or "County") is pleased to offer you health, prescription and dental coverage which is a valuable and important part of your overall compensation package.

This summary gives a general overview your medical/prescription drug benefits and your dental benefits. This document is to be used only for purposes of general benefit information. We encourage you to review the summary and become familiar with your benefits. You may also wish to share this information with your enrolled family members. You may request a copy of the complete Summary Plan Document which describes the plan in detail by contacting the Cherokee County Human Resources Department at (828) 837-2735 ext. 816.

Cherokee County, NC believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). As permitted under the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provisions of preventive health care services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: Cherokee County, NC, 75 Peachtree Street Murphy, NC, 28906, 828-837-2735.

Plan Sponsor and Administrator

|
Cherokee County
75 Peachtree Street
Murphy, NC 28906
828-837-2735

Plan Year

The Plan Year is July 1 through June 30

Deductible and Out of Pocket Year

July 1 – June 30

Medical/COBRA /Utilization Review /Dental Claims Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.
Suite 215
Asheville, NC 28806
828-670-9145
www.crescenths.com

Prescription Drug Administrator

Sona Benefits
805 Fairview Road
Asheville, NC 28803
844--550-1984
Website: www.sonapharmacy.com
Email: Pharmacy@sonapharmacy.com

Summary of Medical Benefits

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days which may be split between Network and Non-Network. **Plan year begins every July 1.**

	In-Network	Out-of-Network
Annual & Lifetime Maximum Paid Benefit (per participant)	No Maximum	No Maximum
Annual Deductible (applies to expenses below unless otherwise noted)	$500 / individual $1,500 / family	$1,000 / individual $3,000 / family
Annual Out-of-Pocket Maximum (includes deductible and coinsurance) **Does not include medical plan copays.**	$3,500 / individual $10,500 / family	$7,000 / individual $21,000 / family

	In-Network	Out-of-Network
Allergy Testing, Serum, and Treatment	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Allergy Shots	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Ambulance Service	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Ambulatory Surgical Center Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Anesthetics, Oxygen, Transfusions	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Chemotherapy Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Chiropractic Care Limited to 30 visits per plan year	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Diagnostic X-rays and Lab Services (includes advanced radiological imaging) MRIs, CT and PET Scans performed on an outpatient basis require precertification.		

	In-Network	Out-of-Network
Performed in and billed by a physician's office	Plan pays 100% after co-payment up to maximum payment of $200 for primary care and $400 for specialist. Then deductible and co-insurance apply. Maximum benefit per visit: $500 for Primary Care and $1,000 for Specialist Care	Plan pays 60% Maximum benefit per visit: $500 for Primary Care and $1,000 for Specialist Care
Performed in and billed by an outside lab/facility	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Dialysis Treatment – Outpatient Please see Appendix A. Precertification required.	100% of Usual and Customary Charges after all applicable deductibles and coinsurance Refer to Dialysis Treatment Outpatient Description in Appendix A	
Durable Medical Equipment Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Emergency/Urgent Care		
Hospital ER Room (copayment waived if for accident or if admitted)	Plan pays 80% (after $150 co-payment) Deductible applies	Plan pays 80% (after $150 co-payment) Deductible applies
Urgent Care Facility (Deductible does not apply In-Network)	Plan pays 100% (after $30 co-payment)	Plan pays 60% (after deductible)
Home Health Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospice Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospital Services		
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospital Services – Outpatient	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Infertility Treatment (includes services for the diagnosis of infertility only) $5,000 Lifetime Maximum	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

	In-Network	Out-of-Network
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions. Maternity benefits covered for employee and spouse pregnancies only.		
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Mental Health and Substance Abuse Treatment		
Doctor's office visits	$50 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $1,000 maximum payment per visit.	Plan pays 60% $1,000 maximum payment per visit.
Outpatient/Intermediate Care	Plan pays 100% (after $50 co-payment)	Plan pays 60% (after deductible)
Inpatient Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Newborn Care – Inpatient	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Organ Transplants Special precertification procedures apply.	See Appendix B for description of network, coverage and limitations.	
Private Duty Nursing Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Primary Care Physician - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	$25 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $500 Maximum payment per visit.	Plan pays 60% $500 Maximum payment per visit.

	In-Network	Out-of-Network
Specialist Physician – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	$50 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $1,000 maximum payment per visit	Plan pays 60% $1,000 maximum payment per visit.
Prosthetics	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Radiation Therapy Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Reconstructive Surgery Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Routine Preventive Care/Wellness Benefits – Plan pays 100% up to maximum combined benefit of $500 (per participant per year) for services shown below.		
Routine Office Visits (periodic and screening exams)	Plan pays 100% (Up to a maximum benefit of $500, then deductible and co-insurance apply)	Plan pays 60% (after deductible)
Routine Gynecological Exam/Pap Smear and Mammogram	Plan pays 100% (Up to a maximum benefit of $500, then deductible and co-insurance apply)	Plan pays 60% (after deductible)
Routine Preventive Care for Infants and Children – Maximum does not apply.		
Well-Child Care	Plan pays 100%	Plan pays 60% (after deductible)
Immunizations	Plan pays 100% (after $25 co-payment)	Plan pays 60% (after deductible)
Well- Baby Care Office Visit	Plan pays 100%	Plan pays 60% (after deductible)
Immunizations	Plan pays 100% (after $25 co-payment)	Plan pays 60% (after deductible)
Routine Patient Costs relating to Approved Clinical Trials	Not Covered	Not Covered
Second Surgical Opinions – voluntary	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Skilled Nursing Facility Limit of 60 days per plan year (combined in- and out-of-network)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

	In-Network	Out-of-Network
Sterilization Procedures	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Surgery		
Hospital Inpatient Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Outpatient Facility Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Therapy Services - Performed in and billed by Physician's office. Performed at outpatient facility or inpatient. Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury). The following therapies are limited to combined maximum visits of 30 per plan year in- and out-of-network: Occupational Therapy and Physical Therapy. Precertification required for outpatient rehabilitation.		
Cardiac Rehabilitation Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Occupational Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Physical Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Pulmonary/Respiratory Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Speech Therapy Speech therapy limited to 30 visits per plan year (combined in- and out-of-network)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

** A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.*

Your Prescription Drug Coverage

	In-Network Retail Pharmacy (up to a 34-day supply)	Mail-Service Program or Retail Pharmacy (up to a 90-day supply)
	Co-Pay	**Co-Pay**
Generic	$10	$25
Preferred Brand Name	$30	$75
Non-Preferred Brand Name	$60	$150
Specialty	Please contact prescription drug administrator	Not Covered

Summary of Dental Benefits

Annual Maximum Benefit (per plan year)	$1,000 per person
Annual Deductible (per plan year)	$25/person $75/family
Orthodontia Maximum Benefit (per lifetime)	$1,000
Orthodontia Deductible (per plan year)	$25/person $75/family

Diagnostic and Preventive Care (Class A) Services	**Plan Pays**
Oral exams (limited to 2 per plan year)	100%
Bite-wing X-Rays (limited to 2 per plan year)	100%
Full mouth x-rays (limited to 1 per 3 year period)	100%
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per plan year)	100%
Topical fluoride applications (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Topical application of sealants on permanent molars (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Space maintainers and their fitting (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Emergency palliative treatment to relieve pain	100%

Therapeutic and Restorative (Class B) Services	**Plan Pays**
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Extraction of teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw (but	80%

Therapeutic and Restorative (Class B) Services	Plan Pays
excluding charges for removal of stitches or post-operative exams)	
Periodontics (treatment of the gums and support structures of the teeth)	80%
Root canals and other endodontic treatments	80%
General anesthetics and their administration in connection with oral surgery, Periodontics, fractures, and dislocations	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Recementing of inlays, crowns, and bridges	80%
Consultations with a specialist	80%

Major and Prosthodontic (Class C) Services	Plan Pays
Relining of full or partial dentures if done more than one year after initial installation	50%
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	50%
Repair of crowns, bridgework, and removable dentures	50%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture, or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	50%
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	50%

Major and Prosthodontic (Class C) Services	Plan Pays
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old	50%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old	50%

Orthodontia Benefits	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	50%