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 including your plan's Plan document, visit www.kerncountyhealthbenefits.com or www.kernpos.com or call the County's Customer Service staff at 1-855-537-6767. 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 www.cciio.cms.gov or call the County's Customer Service staff at 1-855-537-6767 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $0. Out-of-Network Providers: $200/individual; $400/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, at least two family members must meet their individual deductible before the overall family deductible is met.
Are there services covered before you meet your deductible?	Yes. Covered services including preventive care performed by network providers, outpatient prescription drugs, emergency transportation, dental and vision plans (if elected), and out-of-network emergency room services 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?	Yes, depending on the dental plan option you elect, there may be a separate dental plan deductible. There are no other specific deductibles.	You must pay all of the costs for these dental services up to the specific deductible amount before the dental plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan Network Providers: $1,000/individual; $3,000/family per calendar year. Out-of-Network Providers: $2,000/individual; $4,000/family per calendar year. Outpatient prescription drugs: $5,600/individual; $10,200/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?	For the Medical Plan: Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, expenses that are not considered to be essential health benefits, charges in excess of a maximum benefit, dental & vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit). The outpatient prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan, dental plan or vision plan expenses, plus drugs 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 https://www.anthem.com/health-insurance/provider-directory/searchcriteria or call 1-855-537-6767 for a list of Medical Plan and Mental Health and Substance Abuse 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
		Network Provider (You will pay the least)	Out-of-Network 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	$15 copayment/visit.	30% coinsurance.	Preauthorization of certain services is required to avoid non-payment.
	Specialist visit	$25 copayment/visit.	30% coinsurance.	Preauthorization of certain services is required to avoid non-payment.
	Preventive care/screening/ immunization	No charge.	For children up to 2 years: 30% coinsurance to a maximum of $200/year. Preventive care for other ages not covered.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For individuals over age 2 years, you pay 100% for preventive care out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	30% coinsurance.	Preauthorization of Rast allergy testing, drug testing, genetic testing is required to avoid non-payment.
	Imaging (CT/PET scans, MRIs)	No charge.	30% coinsurance.	Preauthorization of imaging tests such as MRI, CT and Pet scans is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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.myWDRX.com or call 1 (855) 537-6767.	Generic drugs	Retail Pharmacy for 30-day supply: No charge at Kern Medical Pharmacies; WellDyneRx pharmacies: $5 copayment per prescription; Mail Order for 90-day supply: $10 copayment per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	• Deductible does not apply to outpatient drugs. • No charge for ACA-mandated preventive drugs, and diabetes drugs and supplies. • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription from an in-network provider, such as FDA-approved female contraceptives and tobacco cessation products. • Drugs accumulate to a separate outpatient prescription drug out-of-pocket limit. • Free workplace desk delivery and reduced copayments for generic medications in Kern affiliated network.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: $15 copayment per prescription; Mail Order for 90-day supply: $30 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: $30 copayment per prescription; Mail Order for 90-day supply: $60 copayment per prescription.		
	Specialty drugs	You pay the same cost sharing as is listed above for Retail pharmacy for a 30-day supply of specialty drugs.	Not covered.	Specialty drugs require preauthorization (to avoid non-payment) by calling US Specialty Care at 1-855-537-6767.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Kern Medical: No charge. Other network hospitals: $100 copayment/admission.	30% coinsurance.	Preauthorization of outpatient surgical facility/center and confinement in a health care facility under an "observation status" is required to avoid non-payment.
	Physician/ surgeon fees	No charge.	30% coinsurance.	
If you need immediate medical attention	Emergency room care	$75 copayment/visit.	$75 copayment/visit.	Copayment waived if admitted. Once discharged from the emergency room or urgent care facility, you should seek follow-up services from a contracted network provider.
	Emergency medical transportation	Emergency or Non-Emergency transportation: No charge.	Emergency: No charge. Deductible does not apply. Non-Emergency transportation: 30% coinsurance.	Preauthorization of non-emergency medical transportation is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$15 copayment/visit.	30% coinsurance.	Once discharged from the emergency room or urgent care facility, in order for benefits to be payable by the Plan, you should seek follow-up services from a contracted network provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	Kern Medical: No charge. Other network hospitals: $150 copayment per day. Maximum $750 hospital admission copayments per person per calendar year.	30% coinsurance.	Preauthorization of elective hospital admission and transplant services is required to avoid non-payment. Private room covered if medically necessary.
	Physician/ surgeon fees	No charge.	30% coinsurance.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $15 copayment/visit. Other outpatient services: $15 copayment/visit.	30% coinsurance.	Plan covers free visits through the Anthem EAP at 1-844-416-6386. Physician/provider's professional fees may be billed separately.
	Inpatient services	Kern Medical: No charge. Other network hospitals: $150 copayment per day. Maximum $750 hospital admission copayments per person per calendar year. Residential treatment facility: $150 copayment per day. Maximum $750 hospital admission copayments per person per calendar year.	Hospital: 30% coinsurance. Residential treatment facility: 30% coinsurance.	Preauthorization of elective hospital admission and residential treatment program admission is required to avoid non-payment.
If you are pregnant	Office visits	No charge for office visits and ACA-required preventive services. Deductible does not apply.	30% coinsurance.	• Cost sharing does not apply for network preventive services. • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth delivery professional services	No charge.	30% coinsurance.	• Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. • If the newborn's delivery is uncomplicated and the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth delivery facility services	Kern Medical: No charge. Other network hospitals: $150 copayment per day. Maximum $750 hospital admission copayments per person per calendar year.	30% coinsurance.	infant is not required to stay in the Hospital longer than the mother, the inpatient Hospital deductible for out-of-network providers will be waived for the infant only.
If you need help recovering or have other special health needs	Home health care	No charge.	30% coinsurance.	• Plan covers part-time or intermittent skilled nursing care to a maximum of 40 visits per calendar year. • Preauthorization of home health care and home infusion therapy services is required to avoid non-payment.
	Rehabilitation services	Outpatient rehabilitation services: No charge. Inpatient rehabilitation admission: 150 copayment per day. Maximum $750 hospital admission copayments per person per calendar year.	30% coinsurance.	• Outpatient rehabilitation: physical, occupational and speech therapy maximum benefit is 60 visits combined per calendar year. • Preauthorization of cardiac, pulmonary, neuro-cognitive, physical, occupational and speech therapy is required to avoid non-payment.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	No charge.	30% coinsurance.	Maximum benefit is 120 days per calendar year. Preauthorization of skilled nursing facility admission is required to avoid non-payment. Payment toward the cost of a private room is limited to the facility's most common semi-private room rate, unless a private room is medically necessary.
	Durable medical equipment	No charge.	30% coinsurance.	Preauthorization of equipment over $250 is required to avoid non-payment. No charge from network providers for breastfeeding pump and supplies needed to operate pump.
	Hospice services	No charge.	30% coinsurance.	Covered if terminally ill. Preauthorization of hospice services is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$20 copayment/visit.	You pay 100%. Plan reimburses up to $35 per exam (minus the $20 copayment for the exam). You pay any amount over $35 for exam. Medical plan deductible does not apply.	• If you elect vision coverage, it will be available under a separate vision plan using the VSP network. • One eye exam per 12 consecutive months. • One frame per 24 consecutive months. One pair of lenses per 24 months. • Your cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	$20 copayment per eyeglasses.	You pay 100%. Plan reimburses up to $30/frame and up to $25/single lens (minus the $20 copayment for the frame and lenses). You pay any amount over $30/frame and $25/single lens. Medical plan deductible does not apply.	
	Children's dental check-up	Your cost depends on the separate dental plan you select. DHMO Plan: No charge. PPO: 10% coinsurance for exam. 10% coinsurance for x-rays.	DHMO: Not covered. PPO: 30% coinsurance for exam; Deductible does not apply. 30% coinsurance for x-rays. Medical plan deductible does not apply to dental services.	If you elect dental coverage, it will be available under a separate dental plan. Your cost sharing for dental services does not count toward the medical plan's out-of-pocket limit.

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 • Cosmetic surgery • Habilitation services.	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Preventive care from out-of-network providers for individuals over age 2 years. • Private-duty nursing • Weight loss programs, except as required by health reform law.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Chiropractic care (payable up to 30 visits/calendar year). • Dental care (Adult) (payable under a separate dental plan) • Hearing aids (max of $7,000 per pair of external aids with a $500 copay per ear.)	• Routine eye care (Adult) (payable under a separate vision plan) • Routine foot care for the treatment of diabetes.

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 the 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 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 the Medical Plan Claims Administrator (HealthEdge Administrators) at 1 855 537 6767.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1 855 537 6767.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 855 537 6767.

Chinese (中文): 如果需要中文的帮助，☒☒打☒个号☒ 1 855 537 6767.

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

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	$0
Specialist copayment	$25
Hospital (facility) for Kern Medical	$0
Other copayment	$0

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	$12,800

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$160

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) for Kern Medical	$0
Other copayment	$0

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	$7,400

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$420

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) ER copayment	$75
Other copayment	$0

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	$1,900

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$180

The plan would be responsible for the other costs of these EXAMPLE covered services.