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 http://www.kernlegacyhp.com/ or call the County's Legacy Max Choice 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 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: $250/individual; $500/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 own individual deductibles 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. Preventive care performed by network providers and outpatient prescription drugs are covered before you meet your deductible. Dental and Vision benefits are separately elected plans, not included in the Medical plan.	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. $100/individual/calendar year for outpatient prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan Network Providers: $5,000/individual; $10,000/family per calendar year. Outpatient prescription drugs (in-network): $1,000/individual; $3,000/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?	For the Medical Plan: Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, dental & vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), expenses that are not considered essential health benefits (such as infertility services) and out-of-network cost sharing except an ER visit in case of an emergency. The outpatient prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan, dental plan and vision plan expenses, 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 full cost if you use an out-of-network provider. 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	$10 copayment/visit.	Not covered.	Preauthorization of certain services is required to avoid non-payment.
	Specialist visit	20% coinsurance.		
	Preventive care/screening/ immunization	No charge. Deductible does not apply.		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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	Not covered.	Preauthorization of Rast allergy testing, drug testing, and genetic testing is required to avoid non-payment. Preauthorization of imaging tests such as MRI, CT and Pet scans is required to avoid non-payment. Physician/provider's professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	20% coinsurance.		

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	Kern Medical Retail Pharmacies for up to a 90-day supply: No charge. Non-Kern Medical Retail Pharmacies for up to a 30-day supply: $5 copayment per prescription. Mail order up to 90-day supply: $10 copayment per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	• Medical Plan Deductible does not apply; however, a separate drug Deductible does apply each calendar year. • No charge for ACA-mandated preventive drugs. • Diabetes supplies covered at the following after drug deductible: lancets: $5 copayment per 30-day supply, test strips: $10 copayment per 30-day supply. • You pay the lesser of the copayment or the drug cost. • 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. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit. • Free workplace desk delivery and reduced copayments for generic medications in Kern affiliated network.
	Preferred brand drugs	Kern Medical Retail Pharmacies for up to a 90-day supply: $25 copayment per prescription. Non-Kern Medical Retail Pharmacies for up to a 30-day supply: $50 copayment per prescription. Mail order up to 90-day supply: $20 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Kern Medical Retail Pharmacies for up to a 90-day supply: $50 copayment per prescription. Non-Kern Medical Retail Pharmacies for up to a 30-day supply: $90 copayment per prescription. Mail order up to 90-day supply: $50 copayment per prescription.		
	Specialty drugs	You pay a $50 copayment (generic), $90 copayment (preferred brand) and $120 copayment (non-preferred brand) per prescription for up to a 30-day supply.		Specialty drugs require preauthorization (to avoid non-payment) by calling US Specialty Care at 1-855-537-6767.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Kern Medical hospital outpatient surgicenter: $50 copayment per outpatient admission. All other outpatient surgery facilities: 20% coinsurance.	Not covered.	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.	Not covered.	Preauthorization of outpatient surgical facility/center and confinement in a health care facility under an "observation status" is required to avoid non-payment.
If you need immediate medical attention	Emergency room care	$150 copayment/visit.	$150 copayment/visit.	Copayment and deductible waived if admitted. Once discharged from the emergency room, you should seek follow-up services from a contracted network provider or the follow-up care will not be covered.
	Emergency medical transportation	Emergency or Non-Emergency transportation: No charge after deductible met	Emergency transportation: No charge after deductible met. Non-Emergency: Not covered	Payable to the nearest appropriate facility as medically necessary for treatment of a medical emergency or acute illness/injury. Preauthorization of non-emergency medical transportation is required to avoid non-payment.
	Urgent care	$15 copayment/visit.	Not covered.	Physician/provider's professional fees may be billed separately. Once discharged from the urgent care facility, you should seek follow-up services from a contracted network provider or the follow-up care will not be covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	Kern Medical: $100 copayment per day up to $2,500 per admission. All other network hospital locations: 20% coinsurance.	Emergency inpatient admission: $100 copayment per day up to $2,500 per admission. Elective inpatient admission: Not covered.	Preauthorization of elective hospital admission and transplant services is required to avoid non-payment. Private room payable only if medically necessary or if the facility does not provide semi-private rooms. If you visit the emergency room of a non-network hospital and require admission to that non-network hospital, the Plan will pay the claims for covered services related to the admission at the non-network level of benefits. When stable, if you need continued hospitalization, the Plan will facilitate your transfer to an in-network facility to complete the treatment.
	Physician/ surgeon fees	No charge.	Not covered.	
If you need mental health, behavioral health, or	Outpatient services	Office visits: $10 copayment/visit. Other outpatient services: $10 copayment/visit.	Not covered.	Plan covers free visits through the Anthem EAP at 1-844-416-6386. Preauthorization of an intensive outpatient program and partial hospitalization 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)	
substance abuse services	Inpatient services	Inpatient hospital and Residential Treatment Program: $100 copayment per day up to $2,500 per admission.	Emergency inpatient admission: $100 copayment per day up to $2,500 per admission. All other services: Not covered.	• 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.	Not covered.	• 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). • 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.
	Childbirth delivery professional services	No charge.	Not covered.	
	Childbirth delivery facility services	Kern Medical: $100 copayment per day up to $2,500 per admission. All other network hospital locations: 20% coinsurance.	Not covered.	
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	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: 20% coinsurance. Inpatient rehabilitation admission: Kern Medical: $100 copayment per day up to $2,500 per admission. All other network hospital locations: 20% coinsurance.	Not covered.	• 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.	Not covered.	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.

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)	
	Durable medical equipment	20% coinsurance.	Not covered.	Preauthorization of certain 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.	Not covered.	Covered if terminally ill. Preauthorization of hospice services is required to avoid non-payment.
If your child needs dental or eye care	Children's eye exam	$20 copayment/visit for exam. $20 copayment/visit for frame and single vision lenses.	You pay 100%. Plan reimburses up to $35 for exam (minus the $20 copayment for the frame and lenses), up to $30 for frame and up to $25 for single vision lenses (minus the $20 copayment for the frame and lenses). You pay any amount over these limits. 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			
	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 (plan covers breast reconstructions after mastectomy) • Habilitation services	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• 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 separate dental plan) • Hearing aids (max of $7,000 per pair of external aids with a $500 copayment per ear.)	• Routine eye care (Adult) (payable under separate vision plan) • Routine foot care (covered when treating diabetic or neurological or vascular insufficiency of feet).

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. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at 1-800-927-4357 or http://www.insurance.ca.gov/consumers.

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*	$250
Specialist coinsurance	20%
Hospital (facility) copayment	$100
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	$290
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$500

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

The plan's overall deductible*	$250
Specialist coinsurance	20%
Hospital (facility) copayment	$100
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*	$350
Copayments	$360
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$750

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

The plan's overall deductible*	$250
Specialist coinsurance	20%
Hospital ER (facility) copayment	$150
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	$250
Copayments	$150
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are other deductibles for specific services?" row above.

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