



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 <u>deductible</u>?	Network Providers: \$250/individual; \$500/family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , at least two family members must meet their own individual <u>deductibles</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> performed by <u>network providers</u> and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> . Dental and Vision benefits are separately elected <u>plans</u> , not included in the Medical <u>plan</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$100/individual/calendar year for outpatient <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical <u>Plan Network Providers</u> : \$5,000/individual; \$10,000/family per calendar year. Outpatient <u>prescription drugs (in-network)</u> : \$1,000/individual; \$3,000/family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	For the Medical <u>Plan</u> : <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>preauthorization</u> , dental & vision <u>plan</u> expenses, outpatient retail/mail order drug expenses (which have a separate <u>out-of-pocket limit</u>), expenses that are not considered essential health benefits (such as infertility services) and out-of- <u>network cost sharing</u> except an ER visit in case of an emergency. The outpatient <u>prescription drug out-of-pocket limit</u> does not include <u>premiums</u> , <u>balance-billing</u> charges, medical <u>plan</u> , dental <u>plan</u> and vision <u>plan</u> expenses, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	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 <u>Network Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the full cost if you use an <u>out-of-network provider</u> . Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a <u>health care provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> /visit.	Not covered.	<u>Preauthorization</u> of certain services is required to avoid non-payment.
	<u>Specialist</u> visit	20% <u>coinsurance</u> .		
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.		Plan covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge.	Not covered.	<u>Preauthorization</u> of Rast allergy testing, drug testing, and genetic testing is required to avoid non-payment. <u>Preauthorization</u> of imaging tests such as MRI, CT and Pet scans is required to avoid non-payment. Physician/ <u>provider's</u> professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> .		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myWDRX.com or call 1 (855) 537-6767.</p>	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 <u>copayment</u> per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	<ul style="list-style-type: none"> • Medical <u>Plan Deductible</u> does not apply; however, a separate drug <u>Deductible</u> does apply each calendar year. • No charge for ACA-mandated preventive drugs, and diabetes drugs and supplies. • You pay the lesser of the <u>copayment</u> or the drug cost. • Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription from an <u>in-network</u> provider, such as FDA-approved female contraceptives and tobacco cessation products. • Your <u>cost sharing</u> counts toward the <u>prescription drug out-of-pocket limit</u>, not the medical <u>plan out-of-pocket limit</u>. • Free workplace desk delivery and reduced <u>copayments</u> for generic medications in Kern affiliated <u>network</u>.
	Preferred brand drugs	Kern Medical Retail Pharmacies for up to a 90-day supply: \$25 <u>copayment</u> per prescription. Non-Kern Medical Retail Pharmacies for up to a 30-day supply: \$50 <u>copayment</u> 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 <u>copayment</u> per prescription. Non-Kern Medical Retail Pharmacies for up to a 30-day supply: \$90 <u>copayment</u> per prescription.		
	<u>Specialty drugs</u>	You pay a \$50 <u>copayment</u> (generic), \$90 <u>copayment</u> (preferred brand) and \$120 <u>copayment</u> (non-preferred brand) per prescription for up to a 30-day supply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Kern Medical hospital outpatient surgicenter: \$50 <u>copayment</u> per outpatient admission. All other outpatient surgery facilities: 20% <u>coinsurance</u> .	Not covered.	<u>Preauthorization</u> of outpatient surgical facility/center and confinement in a health care facility under an "observation status" is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Physician/surgeon fees	No charge.	Not covered.	<u>Preauthorization</u> 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	<u>Emergency room care</u>	\$150 <u>copayment</u> /visit.	\$150 <u>copayment</u> /visit.	<u>Copayment</u> waived if admitted. Once discharged from the emergency room, you should seek follow-up services from a contracted <u>network provider</u> or the follow-up care will not be covered.
	<u>Emergency medical transportation</u>	Emergency or Non-Emergency transportation: No charge after <u>deductible</u> met	Emergency or Non-Emergency transportation: No charge after <u>deductible</u> met.	Payable to the nearest appropriate facility as <u>medically necessary</u> for treatment of a medical emergency or acute illness/injury. <u>Preauthorization</u> of non-emergency medical transportation is required to avoid non-payment.
	<u>Urgent care</u>	\$15 <u>copayment</u> /visit.	Not covered.	Physician/ <u>provider</u> 's professional fees may be billed separately. Once discharged from the <u>urgent care</u> facility, you should seek follow-up services from a contracted <u>network provider</u> or the follow-up care will not be covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	Kern Medical: \$100 <u>copayment</u> per day up to \$2,500 per admission. All other <u>network</u> hospital locations: 20% <u>coinsurance</u> .	Emergency inpatient admission: \$100 <u>copayment</u> per day up to \$2,500 per admission. Elective inpatient admission: Not covered.	<u>Preauthorization</u> of elective hospital admission and transplant services is required to avoid non-payment. Private room payable only if <u>medically necessary</u> or if the facility does not provide semi-private rooms. If you visit the emergency room of a <u>non-network</u> hospital and require admission to that <u>non-network</u> hospital, the <u>Plan</u> will pay the claims for covered services related to the admission at the <u>non-network</u> level of benefits. When stable, if you need continued <u>hospitalization</u> , the <u>Plan</u> will facilitate your transfer to an <u>in-network</u> 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 <u>copayment</u> /visit. Other outpatient services: \$10 <u>copayment</u> /visit.	Not covered.	<u>Plan</u> covers free visits through the Anthem EAP at 1-844-416-6386. <u>Preauthorization</u> of an intensive outpatient program and partial <u>hospitalization</u> is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Inpatient services	Inpatient hospital and Residential Treatment Program: \$100 <u>copayment</u> per day up to \$2,500 per admission.	Emergency inpatient admission: \$100 <u>copayment</u> per day up to \$2,500 per admission. All other services: Not covered.	<ul style="list-style-type: none"> • <u>Preauthorization</u> 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 <u>preventive services</u> . <u>Deductible</u> does not apply.	Not covered.	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for <u>network preventive services</u>. • Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u> or <u>deductible</u> may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • <u>Preauthorization</u> 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 <u>copayment</u> per day up to \$2,500 per admission. All other <u>network</u> hospital locations: 20% <u>coinsurance</u> .	Not covered.	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge.	Not covered.	Plan covers part-time or intermittent <u>skilled nursing care</u> to a maximum of 40 visits per calendar year. <u>Preauthorization</u> of <u>home health care</u> and home infusion therapy services is required to avoid non-payment.
	<u>Rehabilitation services</u>	Outpatient <u>rehabilitation services</u> : 20% <u>coinsurance</u> . Inpatient rehabilitation admission: Kern Medical: \$100 <u>copayment</u> per day up to \$2,500 per admission. All other <u>network</u> hospital locations: 20% <u>coinsurance</u> .	Not covered.	<ul style="list-style-type: none"> • Outpatient rehabilitation: physical, occupational and speech therapy maximum benefit is 60 visits combined per calendar year. • <u>Preauthorization</u> of cardiac, pulmonary, neuro-cognitive, physical, occupational and speech therapy is required to avoid non-payment.
	<u>Habilitation services</u>	Not covered.	Not covered.	You must pay 100% of these expenses, even in- <u>network</u> .
	<u>Skilled nursing care</u>	No charge.	Not covered.	Maximum benefit is 120 days per calendar year. <u>Preauthorization</u> of <u>skilled nursing</u> 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 <u>medically necessary</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	Not covered.	<u>Preauthorization</u> of certain equipment over \$250 is required to avoid non-payment. No charge from <u>network providers</u> for breastfeeding pump and supplies needed to operate pump.
	<u>Hospice services</u>	No charge.	Not covered.	Covered if terminally ill. <u>Preauthorization</u> of <u>hospice services</u> is required to avoid non-payment.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copayment</u> /visit for exam. \$20 <u>copayment</u> /visit for frame and single vision lenses.	You pay 100%. <u>Plan</u> reimburses up to \$35 for exam (minus the \$20 <u>copayment</u> for the frame and lenses), up to \$30 for frame and up to \$25 for single vision lenses (minus the \$20 <u>copayment</u> for the frame and lenses). You pay any amount over these limits. <u>Medical plan deductible</u> does not apply.	<ul style="list-style-type: none"> If you elect vision coverage, it will be available under a separate vision <u>plan</u> using the VSP <u>network</u>. One eye exam per 12 consecutive months. One frame per 24 consecutive months. One pair of lenses per 24 months. Your <u>cost sharing</u> for vision services does not count toward the medical <u>plan's out-of-pocket limit</u>.
	Children's glasses			
	Children's dental check-up	Your cost depends on the separate dental <u>plan</u> you select. DHMO Plan: No charge. PPO: 10% <u>coinsurance</u> for exam. 10% <u>coinsurance</u> for x-rays.	DHMO: Not covered. PPO: 30% <u>coinsurance</u> for exam; <u>Deductible</u> does not apply. 30% <u>coinsurance</u> for x-rays. <u>Medical plan deductible</u> does not apply to dental services.	

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">AcupunctureCosmetic surgery (<u>plan</u> covers breast reconstructions after mastectomy)<u>Habilitation services</u>	<ul style="list-style-type: none">Infertility treatmentLong-term careNon-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">Private-duty nursingWeight 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 <u>plan</u> document.)		
<ul style="list-style-type: none">Bariatric Surgery	<ul style="list-style-type: none">Chiropractic care (payable up to 30 visits/calendar year)Dental care (Adult) (payable under separate dental <u>plan</u>)Hearing aids (max of \$7,000 per pair of external aids with a \$500 <u>copay</u> per ear.)	<ul style="list-style-type: none">Routine eye care (Adult) (payable under separate vision <u>plan</u>)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 <u>plan's</u> overall <u>deductible</u> *	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$290
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u> *	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u> *	\$350
<u>Copayments</u>	\$360
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u> *	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital ER (facility) <u>copayment</u>	\$150
■ Other <u>copayment</u>	\$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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$110
<i>What isn't covered</i>	
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.