



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 Plans Customer Service staff at 661-868-3280 or 1-855-308-5547. 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.ccio.cms.gov or call the County's Legacy Plans Customer Service staff at 661-868-3280 or 1-855-308-5547 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Legacy Share Select EPO <u>Network Providers</u> : \$2,000/individual; \$4,000/family per calendar year. No coverage out-of-network except a medical emergency in an emergency room.	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.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> performed by <u>network providers</u> , certain preventive 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?	No. There are no other specific <u>deductibles</u> for the Medical <u>Plan</u> . The Dental <u>Plan</u> you elect may have <u>deductibles</u> for dental services.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Legacy Share Select <u>Network Providers</u> including outpatient <u>prescription drugs</u> : \$6,000/individual; \$12,000/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>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-approval from the <u>Plan</u> or <u>preauthorization</u> for certain services out-of-network providers (except emergency room expenses in a medical emergency), infertility testing, dental & vision <u>plan</u> expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.kernlegacyhp.com/ProviderLists.aspx or call the County's Health <u>Plan</u> Services staff at 661-868-3280 or 1-855-308-5547 for a list of Select <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 most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</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.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. To avoid non-payment of claims, you need pre-approval from the <u>Plan</u> to see a <u>specialist</u> or any other <u>provider</u> (except a <u>provider</u> of OB/GYN services, chiropractor, a <u>specialist</u> for Mental Health or Substance Use Disorder treatment, or emergency room visit).	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		Legacy Share Select EPO <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> /visit.	Not covered.	To avoid non-payment of claims, you need pre-approval from the <u>Plan</u> to see: <ul style="list-style-type: none"> a <u>specialist</u> (except a <u>provider</u> of OB/GYN services, chiropractor, a <u>specialist</u> for Mental Health or Substance Use Disorder treatment or emergency room visit), or any other <u>provider</u>. <u>Plan</u> 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.
	<u>Specialist</u> visit	\$20 <u>copayment</u> /visit.	Not covered.	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u> met.	Not covered.	To avoid non-payment of Rast allergy testing, drug testing, and genetic testing, you need pre-approval from the <u>Plan</u> .
	Imaging (CT/PET scans, MRIs)	Kern Medical: \$25 <u>copayment</u> per visit. Other Select <u>Network</u> locations: \$50 <u>copayment</u> per visit.	Not covered.	<u>Preauthorization</u> 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
		Legacy Share Select EPO <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.welldynrx.com or call WellDyneRx at 1-888-479-2000.</p>	Generic drugs	After medical <u>plan deductible</u> met, Kern Medical Retail Pharmacies for up to a 90-day supply: No charge. WellDyneRx 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"> The Medical <u>Plan Deductible</u> DOES APPLY to outpatient drugs, except for HDHP <u>preventive care</u> generic drugs, ACA-mandated <u>preventive</u> drugs, and diabetes drugs and supplies. Up to a 90-day supply of drugs available through Kern Medical pharmacies only. 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, such as FDA-approved contraceptives. Drugs do not accumulate to a separate outpatient <u>prescription drug out-of-pocket limit</u> and instead accumulate to the medical <u>plan out-of-pocket limit</u>.
	Preferred brand drugs	After medical <u>plan deductible</u> met, Kern Medical Retail Pharmacies for up to a 90-day supply: \$25 <u>copayment</u> per prescription. WellDyneRx 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	After medical <u>plan deductible</u> met, Kern Medical Retail Pharmacies for 90-day supply: \$50 <u>copayment</u> . WellDyneRx Retail Pharmacies for up to a 30-day supply: \$90 <u>copayment</u> per prescription.		
	<u>Specialty drugs</u>	After medical <u>plan deductible</u> met, for a 30-day supply of <u>specialty drugs</u> , you pay \$50 <u>copayment</u> per prescription for Generic drugs, \$90 <u>copayment</u> per prescription for Preferred Brand drugs, \$120 <u>copayment</u> per prescription for Non-preferred brand drugs.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Legacy Share Select EPO <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Kern Medical facility: No charge after <u>deductible</u> met. Select <u>Network Hospital</u> based outpatient surgery: \$150 <u>copayment</u> /surgery. Select <u>Network</u> free-standing outpatient surgery facility: \$50 <u>copayment</u> /visit.	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.
	Physician/surgeon fees	No charge after <u>deductible</u> met.	Not covered.	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copayment</u> /visit.	\$150 <u>copayment</u> /visit.	Emergency room <u>copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u> met.	No charge after <u>deductible</u> met.	Payable to the nearest acute health care facility qualified to treat the patient's <u>emergency medical condition</u> .
	<u>Urgent care</u>	\$15 <u>copayment</u> /visit.	\$15 <u>copayment</u> /visit.	When outside of Kern County, <u>Urgent Care</u> is \$15.00 <u>copayment</u> /visit. In Kern County, <u>Plan</u> pays when EPO <u>Network Urgent Care</u> facility is used.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copayment</u> per day up to \$500 per person per admission.	Not covered.	<u>Preauthorization</u> of elective hospital admission and transplant services is required to avoid non-payment. Private room covered if <u>medically necessary</u> .
	Physician/surgeon fees	No charge after <u>deductible</u> met.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	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. You do not need pre-approval from your <u>Primary Care Physician</u> (PCP) to see a <u>specialist</u> for Mental Health or Substance Use Disorder treatment. <u>Preauthorization</u> of an intensive outpatient program and partial <u>hospitalization</u> is required to avoid non-payment.
	Inpatient services	Inpatient and Residential Treatment Program: \$100 <u>copayment</u> per day up to \$500 per person per admission. Professional fees: No charge after <u>deductible</u> met.	Not covered.	<u>Preauthorization</u> of an elective inpatient admission and residential treatment program is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Legacy Share Select EPO <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	No charge for ACA-required <u>preventive care</u> . For prenatal/postnatal office visits, no charge after <u>deductible</u> met.	Not covered.	<ul style="list-style-type: none"> <u>Cost sharing (deductible, copayment)</u> does not apply for <u>network preventive services</u>. Depending on the type of services, a <u>copayment</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 after <u>deductible</u> met.	Not covered.	
	Childbirth delivery facility services	\$100 <u>copayment</u> per day up to \$500 per person per admission.	Not covered.	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u> met.	Not covered.	<u>Plan</u> covers part-time or intermittent <u>skilled nursing care</u> to a maximum of 40 visits/calendar year. <u>Preauthorization</u> of home health and home infusion therapy is required to avoid non-payment.
	<u>Rehabilitation services</u>	Outpatient <u>rehabilitation services</u> : No charge. Inpatient rehabilitation admission: \$100 <u>copayment/day</u> . Maximum \$500 hospital admission <u>copayments</u> per person per calendar year.	Not covered.	Outpatient rehabilitation: physical, occupational and speech therapy maximum benefit is 60 visits combined per calendar year. <u>Preauthorization</u> of rehabilitation services 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 after <u>deductible</u> met.	Not covered.	Maximum benefit is 120 days/calendar year. <u>Preauthorization</u> 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 <u>medically necessary</u> .
	<u>Durable medical equipment</u>	No charge after <u>deductible</u> met.	Not covered.	<u>Preauthorization</u> of 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 after <u>deductible</u> met.	Not covered.	Covered if terminally ill. <u>Preauthorization</u> 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
		Legacy Share Select EPO <u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u> /visit under the Medical <u>plan</u> . \$20 <u>copayment</u> /visit under the Vision <u>plan</u> .	Under your Vision <u>Plan</u> you pay 100%. <u>Plan</u> reimburses up to \$35 per exam (minus the \$20 <u>copayment</u> for the exam). You pay any amount over \$35 for exam. Medical <u>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>. Medical <u>plan deductible</u> does not apply to vision services. 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	Under your Vision <u>Plan</u> : \$20 <u>copayment</u> per eyeglasses.	Under your Vision <u>Plan</u> , you pay 100%. <u>Plan</u> reimburses up to \$30/frame and up to \$25/single lens (minus the \$20 <u>copayment</u> for the frame and lenses). You pay any amount over \$30/frame and \$25/single lens. Medical <u>plan deductible</u> does not apply.	
	Children's dental check-up	Your cost depends on the separate dental <u>plan</u> you select. DHMO <u>Plan</u> : No charge. Dental <u>plan deductible</u> does not apply. PPO: 10% <u>coinsurance</u> for exam. Dental <u>plan Deductible</u> does not apply. 10% <u>coinsurance</u> for x-rays.	Under your DHMO: Not covered. Dental PPO: 30% <u>coinsurance</u> for exam; <u>Deductible</u> does not apply. 30% <u>coinsurance</u> for x-rays.	

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.
- 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 20 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 (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 Legacy Share Select EPO Medical Plan Claims Administrator (HealthEdge Administrators) at 1-661-868-3280 or 1-855-308-5547.

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 1-855-308-5547.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-308-5547.

Chinese (中文): 如果需要中文的帮助, ☒☒打☒个号☒ 1-855-308-5547.

-----*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>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment/day</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>	\$2,000
<u>Copayments</u>	\$110
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,120

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>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment/day</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>	\$2,000
<u>Copayments</u>	\$330
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,390

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) ER <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>	\$1,930
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,930

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