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

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes. To avoid non-payment of claims, you need pre-approval from the Plan to see a specialist or any other provider (except a provider of OB/GYN services, chiropractor, a specialist for Mental Health or Substance Use Disorder treatment, or emergency room visit).	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 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.	• To avoid non-payment of claims, you need pre-approval from the Plan to see an out-of-area specialist (except a provider of OB/GYN services, chiropractor, a specialist for Mental Health or Substance Use Disorder treatment or emergency room visit), or a podiatrist.
	Specialist visit	$20 copayment/visit.	Not covered.	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible met.	Not covered.	To avoid non-payment of Rast allergy testing, drug testing, and genetic testing, you need pre-approval from the Plan.
	Imaging (CT/PET scans, MRIs)	Kern Medical: $25 copayment per visit. Other Select Network locations: $50 copayment per visit.	Not covered.	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
		Legacy Share Select 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.welldynerx.com or call WellDyneRx at 1-888-479-2000.	Generic drugs	After medical plan deductible met, Mail Order and CVS Pharmacy for up to a 90-day supply: No charge. WellDyneRx Retail Pharmacies for up to a 30-day supply: $5 copayment per prescription; No charge for ACA-required generic preventive drugs.	Not covered.	• The Medical Plan Deductible DOES APPLY to outpatient drugs, except for HDHP preventive care generic drugs, 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, such as FDA-approved contraceptives. • Drugs do not accumulate to a separate outpatient prescription drug out-of-pocket limit and instead accumulate to the medical plan out-of-pocket limit.
	Preferred brand drugs	After medical plan deductible met, Mail Order and CVS Pharmacy for up to a 90-day supply: $25 copayment per prescription. WellDyneRx Retail Pharmacies for up to a 30-day supply: $50 copayment per prescription. No charge for ACA-required brand name preventive drugs if a generic is medically inappropriate.		
	Non-preferred brand drugs	After medical plan deductible met, Mail Order and CVS Pharmacy for 90-day supply: $50 copayment. WellDyneRx Retail Pharmacies for up to a 30-day supply: $90 copayment per prescription.		
	Specialty drugs	After medical plan deductible met, for a 30-day supply of specialty drugs, you pay $50 copayment per prescription for Generic drugs, $90 copayment per prescription for Preferred Brand drugs, $120 copayment per prescription for Non-preferred brand drugs.	Not covered.	Specialty drugs require preauthorization (to avoid non-payment).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Legacy Share Select 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 facility: No charge after deductible met. Select Network Hospital based outpatient surgery: $150 copayment/admission. Select Network free-standing outpatient surgery facility: $50 copayment/admission.	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 after deductible met.	Not covered.	
If you need immediate medical attention	Emergency room care	$150 copayment/visit.	$150 copayment/visit.	Emergency room copayment waived if admitted.
	Emergency medical transportation	No charge after deductible met.	No charge after deductible met.	Payable to the nearest acute health care facility qualified to treat the patient's emergency medical condition.
	Urgent care	$15 copayment/visit.	$15 copayment/visit.	When outside of Kern County, Urgent Care is $15.00 copayment/visit. In Kern County, Plan pays when EPO Network Urgent Care facility is used.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment per day up to $500 per person per admission.	Not covered.	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 after deductible met.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	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. You do not need pre-approval from your Primary Care Physician (PCP) to see a specialist for Mental Health or Substance Use Disorder treatment. 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
		Legacy Share Select Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	Inpatient and Residential Treatment Program: $100 copayment per day up to $500 per person per admission. Professional fees: No charge after deductible met.	Not covered.	Preauthorization of an elective inpatient admission and residential treatment program is required to avoid non-payment.
If you are pregnant	Office visits	No charge for ACA-required preventive care. For prenatal/postnatal office visits, no charge after deductible met.	Not covered.	• Cost sharing (deductible, copayment) does not apply for network preventive services. • Depending on the type of services, a copayment 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 after deductible met.	Not covered.	
	Childbirth delivery facility services	$100 copayment per day up to $500 per person per admission.	Not covered.	
If you need help recovering or have other special health needs	Home health care	No charge after deductible met.	Not covered.	Plan covers part-time or intermittent skilled nursing care to a maximum of 40 visits/calendar year. Preauthorization of home health and home infusion therapy is required to avoid non-payment.
	Rehabilitation services	Outpatient rehabilitation services: No charge after deductible met. Inpatient rehabilitation admission: $100 copayment/day. Maximum $500 hospital admission copayments per person per admission.	Not covered.	Outpatient rehabilitation: physical, occupational and speech therapy maximum benefit is 60 visits combined per calendar year. Preauthorization of rehabilitation services 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 after deductible met.	Not covered.	Maximum benefit is 120 days/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
		Legacy Share Select Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge after deductible met.	Not covered.	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 after deductible met.	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	$10 copayment/visit under the Medical plan. $20 copayment/visit under the Vision plan.	Under your Vision Plan 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. • Medical plan deductible 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 cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	Under your Vision Plan: $20 copayment per eyeglasses.	Under your Vision Plan, 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. Dental plan deductible does not apply. PPO: 10% coinsurance for exam. Dental plan Deductible does not apply. 10% coinsurance for x-rays.	Under your DHMO: Not covered. Dental PPO: 30% coinsurance for exam; Deductible does not apply. 30% coinsurance for x-rays.	If you elect dental coverage, it will be available under a separate dental plan. No dental coverage under the Medical plan. Medical plan deductible does not apply to dental services. 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.
- 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 on how 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. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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，请拨打这个号码 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 plan's overall deductible** **$2,000**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment/day at Kern Medical** **$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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$160
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,180**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment/day at Kern Medical** **$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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,280**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$20**
- **Hospital (facility) ER copayment at Kern Medical** **$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	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$130
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,130**

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