Kern County Retiree Health Plans for participants Under Age 65

(THESE PLANS ARE NOT MEDICARE PRODUCTS, MEDICARE IS PRIMARY IF ENROLLEE IS ELIGIBLE)

2020

2020 Plan Year	Kern Legacy SHARE SELECT	Kern Legacy NETWORK PLUS		Kern Legacy MAX CHOICE	Kern Legacy CLASSIC CHOICE		KAISER PERMANENTE	Health Net
Monthly Premium: ■ Single ■■ Two-party ■■■ Family	**$ 553.00** **$ 1,080.00** **$ 1,674.00**	**$ 921.00** **$ 1,797.00** **$ 2,787.00**		**$ 1,024.00** **$ 1,884.00** **$ 2,819.00**	**$ 1,743.00** **$ 3,219.00** **$ 4,697.00**		**$ 1,007.20** **$ 2,014.42** **$ 2,850.74**	**$ 1,344.33** **$ 2,688.56** **$ 3,246.44**
Call for Info:	(855) 308-5547	(855) 308-5547		(855) 537-6767	(855) 537-6767		(661) 334-2022	(800) 522-0088
Group No.:				280696 (M007/M008)	280696 (M003/M004)		114416	50874T
Annual Deductible:	$ 2,000 Individual $ 4,000 Family	**EPO TIER** $ 0	**PPO TIER** $ 250 Individual $ 500 Family	$250 Individual $500 Family	**IN-NETWORK** $0	**OUT-OF-NETWORK** $200 Individual $400 Family	$ 0	$ 0
Office Visits:	AFTER DEDUCTIBLE $ 10 copay PCP $ 20 copay Specialist	$ 10 PCP $ 20 Specialist	AFTER DEDUCTIBLE 20% Coinsurance	AFTER DEDUCTIBLE $ 10 copay PCP 20% coinsurance Specialist	$ 15 PCP $ 25 Specialist	AFTER DEDUCTIBLE 70% of R&C	$ 15 Office visit	$ 5 Office visit
Inpatient Hospitalization:	AFTER DEDUCTIBLE $ 100 copay per day/$500 per admission at Kern Medical	$ 0 copay at Kern Medical	AFTER DEDUCTIBLE 20% Coinsurance	AFTER DEDUCTIBLE $ 100 copay Kern Medical 20% coinsurance at other hospitals ($ 2500 max per admit)	$ 0 copay Kern Medical $ 150 copay per day, up to $750	AFTER DEDUCTIBLE 70% of R&C	$ 0	$ 0
Emergency Room:	AFTER DEDUCTIBLE $ 150 copay (waived if admitted)	$ 150 copay (waived if admitted)		AFTER DEDUCTIBLE $ 150 copay (waived if admitted)	$ 75 copay (waived if admitted)		$ 50 copay	$ 35 copay (waived if admitted)
Prescriptions:	$ 10 per Preventative Generic medication (deductible waived) KM Pharmacy (Up to 90 day) $ 0 Generic; $ 25 Preferred; $ 50 Non-Preferred Specialty Medications $ 50 / $ 90 / $ 120 Retail Pharmacy (Up to 30 day) $ 5 / $ 50 / $ 90	KM pharmacy (Up to 90 day supply) $ 0 Generic; $ 20 Preferred; $ 40 Non-Preferred Non-KM pharmacies (Up to 30 day supply) $ 5 / $ 45 / $ 65		<u>AFTER $100 PRESCRIPTION DEDUCTIBLE.</u> KM Pharmacy (Up to 90 day supply) $ 0 Generic; $ 25 Preferred; $ 50 Non-Preferred Retail Pharmacy (Up to 30 day supply) $ 5/ $ 50 /$ 90 Specialty Medications $50 / $ 90 / $ 120	Retail pharmacy (Up to 30 day supply) $ 5 Generic $ 25+ Preferred Brand $ 40+ Non-Preferred Brand Mail Order (Up to 90 day supply) $ 10 / $ 50+ / $ 80+		$ 10 Generic * $ 20 Brand * * Up to 100 day supply at Kaiser Pharmacy	Retail pharmacy (Up to 30 day supply) $ 5 Generic $ 10 Brand $ 35 Non-Formulary Brand Mail Order (Up to 90 day supply) $ 10 / $ 20 / $ 70

Your out-of-pocket cost could be less if you are eligible for the County Stipend contribution of $39.75 (single); $53.69 (two-party); or $61.50 (family), or the Retiree Health Premium Supplement. For additional information visit our website at www.kerncountyhealthbenefits.com.

Kern County Retiree Dental and Vision Plan

Under 65 and Over 65 Retirees are eligible to enroll)

NEW

LIBERTY DENTAL - CA40R PLUS

Monthly Premium

■ Retiree only:	**$ 22.00**
■■ Two-party:	**$ 36.00**
■■■ Family:	**$ 52.00**

DHMO Dental Plan
Annual Deductible: None | Annual Maximum: None
Copays: Refer to Schedule of benefits

Call for info: 1-888-273-3179
www.libertydentalplan.com/countyofkern

VISION SERVICE PLAN (VSP)

Monthly Premium

■ Retiree only:	**$ 9.84**
■■ Two-party:	**$ 19.70**
■■■ Family:	**$ 24.44**

Vision Plan – Group No. 00101371
Vision exam every 12 months: $ 20 copay
Lenses/Frame every 24 months: $ 20 copay
Other copays: Refer to Schedule of Benefits

Call for info: 1-800-877-7195 | www.vsp.com

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