



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 www.kernpos.com or call the **County's 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 the 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>?	<u>Network Providers</u> : \$0. <u>Out-of-Network Providers</u> : \$200/individual; \$400/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 individual <u>deductible</u> before the overall family <u>deductible</u> is met.
Are there services covered before you meet your <u>deductible</u>?	Yes. Covered services including <u>preventive care</u> performed by <u>network providers</u> , outpatient <u>prescription drugs</u> , emergency transportation, dental and vision <u>plans</u> (if elected), and out-of-network <u>emergency room services</u> are covered before you meet your deductible.	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, depending on the dental <u>plan</u> option you elect, there may be a separate dental <u>plan deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these dental services up to the specific <u>deductible</u> amount before the dental <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Medical Plan Network Providers</u> : \$1,000/individual; \$3,000/family per calendar year. <u>Out-of-Network Providers</u> : \$2,000/individual; \$4,000/family per calendar year. <u>Outpatient prescription drugs</u> : \$5,600/individual; \$10,200/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> , expenses that are not considered to be essential health benefits, charges in excess of a maximum benefit, dental & vision <u>plan</u> expenses, outpatient retail/mail order drug expenses (which have a separate <u>out-of-pocket limit</u>). 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> or vision <u>plan</u> expenses, plus drugs 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 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 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.
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	\$15 copayment /visit.	30% coinsurance .	Preauthorization of certain services is required to avoid non-payment.
	Specialist visit	\$25 copayment /visit.	30% coinsurance .	Preauthorization of certain services is required to avoid non-payment.
	Preventive care/screening/immunization	No charge.	For children up to 2 years: 30% coinsurance to a maximum of \$200/year. Preventive care for other ages 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. For individuals over age 2 years, you pay 100% for preventive care out-of-network .
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	30% coinsurance .	Preauthorization of Rast allergy testing, drug testing, genetic testing is required to avoid non-payment.
	Imaging (CT/PET scans, MRIs)	No charge.	30% coinsurance .	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
		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 For more information about prescription drug coverage call CVS at 1-800-364-6331.	Tier 1 drugs	Retail Pharmacy for 30-day supply: \$5 <u>copayment</u> per prescription; CVS Mail Order or CVS, Kroger & Costco Pharmacies for 90-day supply: No charge. No charge for ACA-required Tier 1 preventive drugs.	Not covered.	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply to outpatient drugs. • No charge for ACA-mandated <u>preventive</u> drugs. • Some <u>prescription drugs</u> 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 in-network provider, such as FDA-approved female contraceptives and tobacco cessation products. • Drugs accumulate to a separate outpatient <u>prescription drug out-of-pocket limit</u>.
	Tier 2 drugs	Retail Pharmacy for 30-day supply: \$15 <u>copayment</u> per prescription; CVS Mail Order or CVS, Kroger & Costco Pharmacies for 90-day supply: \$15 <u>copayment</u> per prescription. No charge for ACA-required Tier 2 preventive drugs if a Tier 1 drug is medically inappropriate.		
	Tier 3 drugs	Retail Pharmacy for 30-day supply: \$30 <u>copayment</u> per prescription; CVS Mail Order or CVS, Kroger & Costco Pharmacies for 90-day supply: \$30 <u>copayment</u> per prescription.		
	Tier 4 drugs	You pay the same <u>cost sharing</u> as is listed above for Retail pharmacy for a 30-day supply of <u>Tier 4 drugs</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Kern Medical: No charge. Other <u>network</u> hospitals/surgery center: \$100 <u>copayment/admission</u> .	30% <u>coinsurance</u> .	<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.	30% <u>coinsurance</u> .	
If you need immediate medical attention	<u>Emergency room care</u>	Emergency Room: \$75 <u>copayment/visit</u> .	\$75 <u>copayment/visit</u> .	<u>Copayment</u> and <u>deductible</u> (if applicable) waived if admitted. Once discharged from the emergency room or urgent care facility, you should seek follow-up services from a contracted <u>network provider</u> .

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 immediate medical attention	<u>Emergency medical transportation</u>	Emergency or Non-Emergency transportation: No charge.	Emergency or Air Ambulance: No charge. <u>Deductible</u> does not apply. Non-Emergency transportation: 30% <u>coinsurance</u> .	<u>Preauthorization</u> of non-emergency medical transportation other than Air Ambulance is required to avoid non-payment.
	<u>Urgent care</u>	\$15 <u>copayment</u> /visit.	30% <u>coinsurance</u> .	Once discharged from the emergency room or urgent care facility, you should seek follow-up services from a contracted <u>network provider</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	Kern Medical: No charge. Other <u>network</u> hospitals: \$150 <u>copayment</u> per day. Maximum \$750 hospital admission <u>copayments</u> per person per calendar year.	30% <u>coinsurance</u> .	<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.	30% <u>coinsurance</u> .	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$15 <u>copayment</u> /visit. Other outpatient services: \$15 <u>copayment</u> /visit.	30% <u>coinsurance</u> .	<u>Plan</u> covers free visits through the Anthem EAP at 1-844-416-6386. Physician/ <u>provider</u> 's professional fees may be billed separately.
	Inpatient services	Kern Medical: No charge. Other <u>network</u> hospitals: \$150 <u>copayment</u> per day. Maximum \$750 hospital admission <u>copayments</u> per person per calendar year. Residential treatment facility: \$150 <u>copayment</u> per day. Maximum \$750 hospital admission <u>copayments</u> per person per calendar year.	Hospital: 30% <u>coinsurance</u> . Residential treatment facility: 30% <u>coinsurance</u> .	
If you are pregnant	Office visits	No charge for office visits and ACA-required <u>preventive services</u> . <u>Deductible</u> does not apply.	30% <u>coinsurance</u> .	<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).

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)	
	Childbirth delivery professional services	No charge.	30% <u>coinsurance</u> .	<ul style="list-style-type: none"> <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. If the newborn's delivery is uncomplicated and the infant is not required to stay in the Hospital longer than the mother, the inpatient Hospital <u>deductible</u> for <u>out-of-network providers</u> will be waived for the infant only.
	Childbirth delivery facility services	Kern Medical: No charge. Other <u>network</u> hospitals: \$150 <u>copayment</u> per day. Maximum \$750 hospital admission <u>copayments</u> per person per calendar year.	30% <u>coinsurance</u> .	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge.	30% <u>coinsurance</u> .	<ul style="list-style-type: none"> <u>Plan</u> 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> : No charge. Inpatient rehabilitation admission: 150 <u>copayment</u> per day. Maximum \$750 hospital admission <u>copayments</u> per person per calendar year.	30% <u>coinsurance</u> .	<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.	30% <u>coinsurance</u> .	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> .
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	No charge.	30% <u>coinsurance</u> .	<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.	30% <u>coinsurance</u> .	Covered if terminally ill. <u>Preauthorization</u> of <u>hospice services</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)	
If your child needs dental or eye care	Children's eye exam	\$20 <u>copayment</u> /visit.	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>. 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	\$20 <u>copayment</u> per eyeglasses.	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 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. Medical <u>plan deductible</u> does not apply to dental services.	If you elect dental coverage, it will be available under a separate dental <u>plan</u> . Your <u>cost sharing</u> for dental services does not count toward the medical <u>plan's out-of-pocket limit</u> .

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.
- Preventive care from out-of-network providers for individuals over age 2 years.
- 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 a 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 a separate vision plan)
- Routine foot care for the treatment of diabetes.

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 Medical Plan Claims Administrator (HealthEdge Administrators) at 1 855 537 6767.

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 1 855 537 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, 请拨打这个号码 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>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) for Kern Medical	\$0
■ 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	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$30

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>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) for Kern Medical	\$0
■ 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	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$580
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$580

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) ER <u>copayment</u>	\$75
■ 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	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$180
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$180

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