



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 **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.cciio.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 deductible?	Legacy Share Select EPO <u>Network Providers</u> : \$2,000/individual; \$4,000/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.
Are there services covered before you meet your deductible?	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 deductibles 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 out-of-pocket limit for this plan?	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 out-of-pocket limit?	<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 network provider?	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.
Do you need a referral to see a specialist?	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 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.	<ul style="list-style-type: none"> To avoid non-payment of claims, you need pre-approval from the <u>Plan</u> to see an out-of-area <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 a podiatrist. <p><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.</p>
	<u>Specialist</u> visit	\$20 copayment /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> .
	<u>Imaging</u> (CT/PET scans, MRIs)	Kern Medical: \$25 copayment per visit. Other Select <u>Network</u> locations: \$50 copayment 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 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	After medical <u>plan deductible</u> met, CVS Mail Order and CVS, Kroger & Costco Pharmacies for up to a 90-day supply: No charge. Retail Pharmacies for up to a 30-day supply: \$5 <u>copayment</u> per prescription; No charge for ACA-required Tier 1 preventive drugs.	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> Tier 1 drugs, ACA-mandated <u>preventive</u> drugs, and diabetes drugs and supplies. 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>.
	Tier 2 drugs	After medical <u>plan deductible</u> met, CVS Mail Order and CVS, Kroger & Costco Pharmacies for up to a 90-day supply: \$25 <u>copayment</u> per prescription. Retail Pharmacies for up to a 30-day supply: \$50 <u>copayment</u> per prescription. No charge for ACA-required Tier 2 preventive drugs if a generic is medically inappropriate.		
	Tier 3 drugs	After medical <u>plan deductible</u> met, CVS Mail Order and CVS, Kroger & Costco Pharmacies for 90-day supply: \$50 <u>copayment</u> . Retail Pharmacies for up to a 30-day supply: \$90 <u>copayment</u> per prescription.		
	Tier 4 drugs	After medical <u>plan deductible</u> met, for a 30-day supply of Tier 4 drugs, you pay \$50 <u>copayment</u> per prescription for Tier 1 drugs, \$90 <u>copayment</u> per prescription for Tier 2 drugs, \$120 <u>copayment</u> per prescription for Tier 3 drugs.		

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 <u>deductible</u> met. Select <u>Network</u> Hospital based outpatient surgery: \$150 <u>copayment/admission</u> . Select <u>Network</u> free-standing outpatient surgery facility: \$50 <u>copayment/admission</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.
	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/visit</u> .	\$150 <u>copayment/visit</u> .	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/visit</u> .	\$15 <u>copayment/visit</u> .	When outside of Kern County, <u>Urgent Care</u> is \$15.00 <u>copayment/visit</u> . 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/visit</u> . Other outpatient services: \$10 <u>copayment/visit</u> .	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.

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 <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.
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 after <u>deductible</u> met. Inpatient rehabilitation admission: \$100 <u>copayment</u> /day. Maximum \$500 hospital admission <u>copayments</u> per person per admission.	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> .

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)	
	<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.
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.	If you elect dental coverage, it will be available under a separate dental <u>plan</u> . No dental coverage under the Medical <u>plan</u> . Medical <u>plan deductible</u> does not apply to dental services. 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.
- 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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment/day</u> at Kern Medical	\$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	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$160
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment/day</u> at Kern Medical	\$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	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$280
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) ER <u>copayment</u> at Kern Medical	\$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	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$130
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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.