County of Kern

Plan Document describing these Medical Plan Options for Active Employees

Kern Legacy Select Medical Plan
Kern Legacy Network Plus Medical Plan
EPO Medical Plan
POS Medical Plan

Amended, restated and effective January 1, 2018

Kern County Health Plan | 1115 Truxtun Ave, 1st Floor | Bakersfield CA 93301 | (661) 868-3280 | 1 (855) 308-5547

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Kern County HR

County Administrative Office

1115 Truxtun Avenue, 1st Floor, Bakersfield, CA 93301
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Ryan Alsop
County Administrative Officer

Devin Brown
Chief Human Resources Officer

Dear Plan Participants:

This is the Plan Document for the self-funded Medical Plan benefits of the County of Kern for Active Employees, ("Plan), describing the Medical plan options available to eligible employees and their eligible dependents and includes outpatient prescription drug benefits. These Plan benefits are designed to help cover many of your expenses when you become sick or are injured. In addition, the medical **plans also provide an array of preventive/wellness services** to help you maintain your current good health and to identify health risk factors that can, if not corrected, eventually lead to chronic diseases.

Here are some important tips on using your Medical benefits:

- ✓ All the Medical Plan options give you access to a network of preferred providers who extend a discount off their usual cost of services to you and your enrolled family. **Using preferred providers will result in a substantial savings to you and to the Plan**.
- ✓ Because preferred network providers can be added to or removed from the network each month, it is a **wise idea to check with the Plan Administrator to see if the provider is still participating in the network before you schedule an appointment or go get lab work or x-rays**.
- ✓ **Certain services require prior authorization** (pre-approval) before the service is performed in order to avoid non-payment of that service. This includes certain medical plan services and certain outpatient prescription drugs and is discussed in the Utilization Management chapter.
- ✓ Notify your County Human Resource Department of any **address change** to ensure that you receive updated Plan and COBRA information. Be sure to inform the County of any **changes in the status of your Eligible Dependents** (for example, marriage, divorce, child reaches the age of 26 years).
- ✓ Important and helpful contact information is listed on the **Contact Information Chart** located in the front of this document.

The County makes every effort to administer the Medical Plans carefully making changes to your Plan as the Plan's financial condition changes and as mandated by law. Eligibility provisions may be modified in accordance with law, and medical and drug benefits may be increased or decreased (amended) from time to time. You will be notified if there are plan changes.

Sincerely,

The County of Kern

INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This document serves as the Plan Document for the County of Kern Health Plan describing these self-funded Medical Plan options for active employees and their eligible dependents:

- Kern Legacy Select Medical Plan
- Kern Legacy Network Plus Medical Plan
- EPO Medical Plan
- POS Medical Plan

For information on other insured medical plan options offered to employees by the County, or for information on Dental and Vision plan options, contact the County of Kern Human Resources Division. Benefits for Retirees are explained in a separate Retiree Only Plan Document available from the County of Kern Human Resources Division. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.

- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

The Plans described in this document are effective January 1, 2018 and replaces all other plan documents and applicable amendments to those documents previously provided to Plan participants.

This document will help you understand and use the self-funded medical plan benefits provided by the County of Kern. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan.

While recognizing the many benefits associated with the Plans, it is also important to note that **not every expense you incur for health care is covered by the Plans**. Be sure to read the Exclusions and Definitions chapters.

These Plans are **not** established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical plan benefits described in this document are self-funded with contributions from the County of Kern and eligible employees used to pay Plan benefits. Independent Claims Administrators pay benefits out of general County assets.

IMPORTANT INFORMATION

The County of Kern is committed to maintaining health care coverage for employees and their families at an affordable cost; however, because future conditions cannot be predicted, the County reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

If you do not understand English, contact the County of Kern Human Resources Division to find out if assistance is available. See also the *General Provisions* chapter for information for individuals with limited English proficiency.

- SPANISH (Español): Para obtener asistencia en Español, llame al (661) 868-3182.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (661) 868-3182.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (661) 868-3182.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Contact Information Chart to sources of help or information about the Plan appears in this chapter.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions chapter. The **Table of Contents** provides you with an outline of the chapters.
- This document contains a **Contact Information Chart** following this introductory text**.** This is a handy resource for the names, addresses, phone numbers and websites of the key contacts for your benefits such as the Medical Plan Claims Administrator(s), outpatient Prescription Drug Program, or Provider Network.
- The **Eligibility chapter** reminds you where to find information on who is eligible for coverage, how to enroll for benefits under these Medical Plan and the event that can cause a termination of benefits.
- Review the **Medical Expense Benefits** chapter for information on your cost-sharing including deductibles, copayment and coinsurance and well as the maximum cost-sharing, you pay each year under your Medical plan, referred to as the Out-of-Pocket Limit.
- **There are two separate Schedules of Medical Benefits:** one to describe the benefits of the Kern Legacy Select Medical Plan and the Kern Legacy Network Plus Medical Plan, and a second Schedule of Medical Benefits to describe the benefits of the EPO Medical Plan and the POS Medical Plan. These Schedules describe your Medical Plan benefits and cost-sharing in more detail. There are examples and text to help clarify the details of the coverages provided, along with tips on other chapters or sections of the document that would be useful for you to review.
- **In the Medical Plan Exclusions chapter** you will see information on services not payable by the Medical plans described in this document.
- Review the **Medical Networks and the Prior Authorization and Utilization Management Program chapters**. They describe how you can maximize plan benefits by following the provisions explained in these chapters.
- Refer to the **General Provisions chapter** for information regarding your rights and important notices for you, while the **Claim Filing and Appeal Information chapter** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The chapter on **Coordination of Benefits (COB)** discusses situations where you have coverage under a County sponsored medical plan plus you have another group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, or workers' compensation, or where you can recover expenses from any other source.
- The **COBRA chapter** discusses options if coverage ends for you or a covered Spouse or Dependent Child while the **Definitions chapter** defines and explains many technical, medical and legal terms that appear in the text.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the County of Kern Human Resources Division information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan of any of these changes within 30 days. Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give the County's Human Resources Division a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical benefits.

There may be circumstances when a Member and the treating medical provider determine that medical care which is not covered by the Plan is appropriate. All decisions regarding medical care are up to a Member and the treating medical provider. Determination of benefits is solely at the discretion of the County of Kern (as Plan Sponsor) and its designated administrators.

Common terms used in this document include:

- **Subscriber.** The individual enrolled as an eligible County of Kern Active employee or non-employee such as an elected official or member of the County Board of Supervisors.
- **Dependents.** The subscriber's eligible spouse, children, or other qualified individual, such as Domestic Partner.
- **Member.** Individuals eligible and enrolled (covered) under the health plan (also called Plan participants) including eligible enrolled subscriber as well as any eligible enrolled dependents.

SELF-INSURED (SELF-FUNDED) MEDICAL PLANS

What is a self-insured/self-funded plan? This means that County of Kern, the Plan Sponsor, assumes sole financial risk for covered services provided to eligible Active Employees and their eligible dependents enrolled in the self-insured Medical Plans described in this document. The County contracts with various independent health plan admnistrators, claims administrators and medical management firms (called UM Companies) to assist in managing their self-funded plans, as noted on the Contact Information Chart at the front of this document.

INTERPRETING THE PLAN'S PROVISIONS

In order to fairly administer the provisions of these plans, the County of Kern reserves the exclusive authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of the Plan or any resolutions, administrative rules and regulations, contracts or writings that the County of Kern might adopt or enter into. In addition, the County of Kern reserves the right to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan. Part or all of this authority and discretion might be delegated to others, such as the third-party administrators or the Claims Administrators, as described in the Contact Information Chart in the front of this document. See also the General Provisions chapter.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the County of Kern Human Resources Division at their phone number and address located on the Contact Information Chart in this document. As a courtesy to you, the County of Kern Human Resources Division staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the County of Kern Human Resources Division and obtain a written response from the County of Kern Human Resources Division. In the event of any discrepancy between any information that you receive from the County of Kern Human Resources Division, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the individuals listed in the Contact Information Chart on the next page:

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Eligibility and Medical Plan Information • Eligibility for benefits, coverage rules • Qualified medical child support order, addresses of dependents not living with subscriber, or benefit arrangements while on FMLA • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • Medical Plan document • Online benefits enrollment	**County of Kern, County Administrative Office – Human Resources Division – Health Benefits** **Phone:** (661) 868-3182 Business Hours: Monday - Friday 8 am - 5 pm Fax: (661) 868-3110 E-mail: healthbenefits@kerncounty.com Address: 1115 Truxtun Ave, 1st Floor Bakersfield, CA 93301 Website: www.kerncountyhealthbenefits.com
Contacts for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan	
Plan Administrator for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan	**County of Kern, County Administrative Office – Human Resources Division – Kern Legacy Health Plan** **Phone:** (661) 868-3280 or 1 (855) 308-5547 option 1 and then 5. Address: 1115 Truxtun Ave 1st Floor Fax (661) 868-3295 Email: KLHP@kerncounty.com
Claims Administrator for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan • Medical Plan claim filing and claim appeals • Questions about Explanation of Benefits (EOB's) • Plan Benefit Information • Help understanding the covered wellness/preventive benefits payable by the Medical Plan	**HealthEdge Administrators** **Phone:** (661) 868-3280 or, 1 (855) 308-5547, select option 1 then 1 to be routed to the Medical Plan Claims Administrator Fax: (661) 616-4889 For Electronic Claims Submission: Payer ID #89890 Mailing address: P.O. Box 11210 Bakersfield CA 93389-1210 Website: www.kernlegacyhp.com

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Contacts for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan	
Network Providers for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan • Medical Network Provider Directory (no charge) • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	**Kern Legacy Select Medical Plan uses:** - **Kern Health Care Network – Select Network** **Kern Legacy Network Plus Plan uses:** - **For the EPO Tier: the Kern Health Care Network – EPO Network** - **For the Plus Tier: the Kern Health Care Network – Plus Network** **County of Kern, County Administrative Office - Human Resources Division – Kern Legacy Health Plan** **Phone:** (661) 868-3280 or 1 (855) 308-5547 To locate a network provider select option 1 then 2. Website for Online Network Provider Directory: www.kernlegacyhp.com **CAUTION:** Use of a **non**-network hospital, facility or Health Care Provider could result in you having to pay the non-network provider's bill.
Outpatient Prescription Drug Program for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan, administered by the Pharmacy Benefit Manager (PBM) • ID Cards • Network Pharmacies including Retail and Kern Medical Pharmacies • Desk Delivery Service • Prescription Drug Information • Formulary of Preferred Drugs • Preventive Drug Listing • Prior Authorization of Certain Drugs • Specialty Drugs • Submit a manual claim for reimbursement	**WellDyneRx** **Phone:** (661) 868-3280 or, 1 (855) 308-5547, select option 1 then 4 Website: www.myWDRX.com **Outpatient Pharmacy and Desk Delivery Service:** Sagebrush Outpatient Pharmacy 1111 Columbus St., Suite 2000 Bakersfield, CA 93305 Pharmacy Phone (661) 326-6580 Desk Delivery Phone: (661) 862-7510 Refills (661) 326-6581 Fax (661) 326-6582 **Outpatient Pharmacy Including Specialty Drugs:** Kern Medical Campus Pharmacy 2014 College Ave Bakersfield, CA 93305 Phone (661) 326-2506 Refills (661) 326-2860 Fax (661) 862-7652 **Electronic Claims:** Pharmacies may submit claims electronically to the WellDyneRx online system. RxGroup: see ID card. BIN# 008878. Processor: NetCard.

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Contacts for the Kern Legacy Select Medical Plan and Kern Legacy Network Plus Medical Plan	
Utilization Management (UM) Program for the Kern Legacy Select Medical Plan, Kern Legacy Network Plus Medical Plan • Prior Authorization of Medical Plan Services • Check status on a request for prior authorization or continuity of care • Referrals • Nurse Advice (available during business hours only) • Medical Management • Appeals of UM decisions	**County of Kern, County Administrative Office – Human Resources Division – Kern Legacy Health Plan and Clinix Healthcare** **Phone:** (661) 868-3280 or 1 (855) 308-5547 - select option 1 then 3. Fax: (661) 868-3291
Contacts for the EPO Medical Plan	
Claims Administrator for the EPO Medical Plan • Medical Plan claim filing and claim appeals • Questions about Explanation of Benefits (EOB's) • Plan Benefit Information • Help understanding the covered wellness/preventive benefits payable by the Medical Plan	**Dignity Health Management Services (DHMS)** (formerly Managed Care Systems (MCS)) **Phone:** 661-716-3450 or 888-587-8810 4550 California Ave, Suite 500 Bakersfield, CA 93309 Website: http://www.kerncountyhealthbenefits.com/epo.aspx
Network Providers for the EPO Medical Plan • Medical Network Provider Directory (no charge) • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	**County of Kern EPO Network** **Phone**: (661) 716-3450 Website for Online Network Provider Directory: https://www.managedcaresystems.com/EPO/countyepo/ The medical network includes: Golden Empire Managed Care (GEMCare) Medical Group and Delano Medical Group (DMG) and the network covers Kern County including the Ridgecrest area. **MCS is the Chiropractic network for the EPO Medical Plan**. To locate a network chiropractor, call MCS at 1-888-587-8810 or use their website at www.managedcaresystems.com. **CAUTION:** Use of a **non**-network hospital, facility or Health Care Provider could result in you having to pay the non-network provider's bill.
Utilization Management (UM) Program for the EPO Medical Plan • Prior Authorization of Medical Plan Services • Check status on a request for prior authorization or continuity of care • Referrals • Nurse Advice (available during business hours only) • Medical Management • Appeals of UM decisions	**Dignity Health Management Services (DHMS)** (formerly Managed Care Systems (MCS)) **Phone:** 661-716-3450 or 888-587-8810 Website: http://www.kerncountyhealthbenefits.com/epo.aspx

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Contacts for the EPO Medical Plan	
Outpatient Prescription Drug Program for the EPO Medical Plan, administered by the Pharmacy Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Desk Delivery Service • Prescription Drug Information • Formulary of Preferred Drugs • Prior Authorization of Certain Drugs • Specialty Drugs • Submit a manual claim for reimbursement	**National Pharmaceutical Services (NPS)** **Phone:** 1-800-546-5677 (TTY: 1 (866) 706-4757) Integrated Home Mail Order (IHMO) Service Mailing Address: National Pharmaceutical Services PO Box 407 Boys Town, NE 68010 Website: www.pti-nps.com or https://npsonline.pti-nps.com/ Diabetes blood glucose meter: (Visit https://www.myfreestyle.com/insurance-coverage to select a new meter, which will be shipped to you directly from Abbott.)
Contacts for the POS Medical Plan	
Claims Administrator for the POS Medical Plan • Medical Plan claim filing and claim appeals • Questions about Explanation of Benefits (EOB's) • Plan Benefit Information • Help understanding the covered wellness/preventive benefits payable by the Medical Plan	**HealthEdge Administrators** **Phone:** 1 (855) 537-6767, select option 1 then 3 to be routed to the Medical Plan Claims Administrator Fax: (661) 616-4889 For Electronic Claims Submission: Payer ID #89890 Mailing address: P.O. Box 11210 Bakersfield CA 93389-1210 Website: http://www.kernpos.com/
Network Providers for the POS Medical Plan • Medical Network Provider Directory (no charge) • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	**Anthem Blue Cross Network** **Phone:** 1 (855) 537-6767 Website for Online Network Provider Directory: https://www.anthem.com/health-insurance/provider-directory/searchcriteria Enter "KEK" in the search for "alpha prefix" to find a physician covered by the POS Medical Plan The POS Plan uses the **Anthem Prudent Buyer** (**Large Group) Network** **CAUTION:** Use of a **non**-network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. (See definition of "balance billing" in the Definition chapter of this document). **Your lowest out of pocket costs will occur when you use Network providers**.

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Contacts for the POS Medical Plan	
Utilization Management (UM) Program for the POS MEDICAL PLAN • Prior Authorization of Medical Plan Services • Check status on a request for prior authorization or continuity of care • Referrals • Nurse Advice (available during business hours only) • Medical Management • Appeals of UM decisions	**Clinix Healthcare** **Phone:** 1-855-619-2211
Outpatient Prescription Drug Program for the POS Medical Plan, administered by the Pharmacy Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies including Kern Medical pharmacies • Desk Delivery Service • Prescription Drug Information • Formulary of Preferred Drugs • Prior Authorization of Certain Drugs • Specialty Drugs • WellDyneRx Healthy Steps, diabetes healthy living program including free glucose meter • Submit a manual claim for reimbursement	**WellDyneRx** **Phone:** 1 (855) 537-6767, select option 1 then 4 Website: www.myWDRX.com **Specialty Drugs:** **U.S. Specialty Care** Phone: 1-855-537-6767, select option 1, then 4 www.usspecialtycare.com **Desk Delivery service:** Sagebrush Outpatient Pharmacy 1111 Columbus St., Suite 2000 Bakersfield, CA 93305 Pharmacy Phone (661) 326-6580 Desk Delivery Phone (661) 862-7510 Refills (661) 326-6581 Fax (661) 326-6582 **Electronic Claims:** Pharmacies may submit claims electronically to the WellDyneRx online system. RxGroup: see ID card. BIN# 008878. Processor: NetCard.
Contacts Related to all Medical Plan Options	
Employee Assistance Program (EAP) • The EAP Program provides professional, confidential information, support, short-term counseling and referral (at no cost) to help individuals cope with personal problems that impact their home and work life. Additional mental health and substance abuse treatment services are available under your medical plan. • EAP counselors can help you (24 hours a day, 7 days a week, all year long) with stress, marriage, family, work-related problems, substance abuse (alcohol and drug treatment), crisis intervention along with financial and legal problems. • **All plan participants are eligible for the EAP services**. Each of your household members are also eligible – spouse, children, etc. • There is no waiting period to start using the EAP. You also do not need to be enrolled in any other benefits to be eligible to use the EAP.	**Anthem EAP** **Phone:** 1-844-416-6386 Website: www.anthemeap.com and enter "County of Kern" to login

CONTACT INFORMATION CHART

Information Needed	Whom to Contact
Contacts Related to all Medical Plan Options	
Health Savings Account (HSA) Administrator • Administration of the Health Savings Account that is combined with the High Deductible Health Plan option (Kern Select Plan). • General information • Opening an HSA account • Contributions to an HSA account • Reimbursement from an HSA account	**American Fidelity** **Phone:** (800) 662-1113 Address: P. O. Box 268887 Oklahoma City, OK 73126 Website: hsa-support@americanfidelity.com (Portal: afhsa.com)
COBRA Administrator • Information About COBRA Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification • COBRA Election Notice	**Administrative Solutions, Inc. (ASI)** **Phone:** 1-866-777-1320 Website: www.asibenefits.com Address: 555 W. Shaw Ave. Suite C-1, Fresno, CA 93704 Mailing address: P.O. Box 5809, Fresno, CA 93755
Plan Administrator for Claim Appeal Review • Claim Appeals for the Kern Legacy Select Medical Plan, the Kern Network Plus Medical Plan, the EPO Medical Plan and the POS Medical Plan.	**For the Kern Legacy Select and Network Plus Plans: County of Kern, County Administrative Office – Human Resources Division – Health Benefits** **Phone:** (661) 868-3280 or 1 (855) 308-5547 and select option 1, then 5 Business Hours: Monday - Friday 8 am - 5 pm Fax: (661) 868-3110 E-mail: healthbenefits@kerncounty.com Address**:** 1115 Truxtun Ave, 1st Floor Bakersfield, CA 93301 **For the EPO Medical Plan:** Phone is 661-716-3450 **For the POS Medical Plan:** Phone is 1 (855) 537-6767, select option 1 then 3 to be routed to the Medical Plan Claims Administrator
Flexible Spending Account (FSA) Administrator • Health FSA • Dependent Care Assistance Program (DCAP)	**Administrative Solutions, Inc. (ASI)** **Phone:** 1-866-777-1320 Website: www.asibenefits.com Address: 555 W. Shaw Ave. Suite C-1, Fresno, CA 93704 Mailing address: P.O. Box 5809, Fresno, CA 93755
Voluntary Benefits Administrator • Election of Voluntary Benefits such as short term disability, long term disability, critical illness, cancer and hospital confinement, legal and life insurance.	**Chimienti and Associates** **Phone:** 1-877-733-1670 Address: 3400 W. Mineral King Ave B Visalia, CA 93291
Fully Insured HMO Medical Plan *(not described in this document)* • Network Provider Directory • Claims and Appeals for the HMO Medical Plan • Outpatient drugs for the HMO Medical Plan	**Kaiser Permanente** **Phone:** 1-800-278-3296 or 1-800-464-4000 Website to locate providers: www.kp.org Nurse Line (24/7): 888-576-6225

CONTACT INFORMATION CHART	
Information Needed	**Whom to Contact**
Contacts Related to all Medical Plan Options	
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**County of Kern Privacy and Security Officer** **Phone:** 661-868-3178 Address: Attn: Chief Human Resources Officer 1115 Truxtun Ave, 1st Floor Bakersfield, CA 93301
Plan Sponsor/Plan Administrator	**County of Kern** County of Kern, County Administrative Office - Human Resources Division – Health Benefits **Phone:** (661) 868-3280 or 1 (855) 308-5547 and select option 1, then 5 Business Hours: Monday - Friday 8 am - 5 pm Fax: (661) 868-3110 E-mail: healthbenefits@kerncounty.com Address: 1115 Truxtun Ave, 1st Floor Bakersfield, CA 93301

ELIGIBILITY
HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

Eligibility and Enrollment Information

The County of Kern – Human Resources Division oversees all Health Benefit programs. Please refer to the County of Kern Health Benefits Eligibility Policy booklet for the County's policy and procedures about the following:

- An employee and dependents' eligibility for coverage.
- How to enroll for coverage including proof of dependent status.
- When coverage begins and ends.
- Leaves of absence (LOA), such a FMLA and Military leave.
- Reinstatement of coverage after a break in service.

Obtain a copy of the Eligibility Policy booklet from the County website:
http://www.kerncountyhealthbenefits.com/pdf/eligpolicy-active-employee.pdf **Or**: request a copy from the County Health Benefits staff. The Eligibility policy booklet explains who is eligible for benefits, how to enroll and the various enrollment times permitted under this Plan.

The County of Kern determines full-time employee status in compliance with IRS regulations under the Affordable Care Act. Individuals are eligible for health plan benefits in accordance with the rules explained in the County's Health Benefits Eligibility Policy located on the County website: http://www.kerncountyhealthbenefits.com/pdf/eligpolicy-active-employee.pdf or request a copy from the County Health Benefits staff.

For information about how the County enforces the requirements of the federal law called Health Insurance Portability and Accountability Act (HIPAA), please refer to the County of Kern Employee Benefits Plan Notice of Privacy Practices at *http://www.kerncountyhealthbenefits.com/pdf/hipaa.pdf.*

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE (RESCISSION)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid (in full), or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

A. The Plan Administrator or its designee may end your coverage (retroactively to the date that you or your covered Dependent performed or permitted the acts described below) and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:
   1. **engages in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, ex-Domestic Partner, over-age or ineligible dependent child, etc.) is considered fraud; or
   2. **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
   3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

   If your coverage is terminated for any of the above reasons, it will typically be terminated retroactively (a rescission) to the date that you or your covered Dependent performed or permitted the acts described above.

   For example, you must immediately notify the County of Kern Human Resource Division, in writing, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. A failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the Participant and ineligible Dependent. Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage under this Plan.

B. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause **30 days** after it gives you written notice of its finding that you or your covered Dependent(s) engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward (prospective) basis.

C. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage will typically be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

HIGH DEDUCTIBLE HEALTH PLAN AND HEALTH SAVINGS ACCOUNT

The High Deductible Health Plan (HDHP) listed in this document (called the **Kern Legacy Select Plan**) is intended to comply with Code §223(c)(2) to allow the County (when applicable) and eligible members to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually (when needed) in connection with applicable IRS rules, and as appropriate for Plan administration.

A Health Savings Account is an account owned by an eligible member. Money deposited into the health savings account can be used (tax-free) by the member only for qualified medical expenses and the funds in the account never expire. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction for you, your Spouse and tax-qualified dependent children. To be reimbursed on a tax-free basis, qualified medical expenses must be incurred after the HSA has been established.

The IRS determines the types of eligible medical expenses that are permitted for tax-free withdrawals from the HSA and it is ultimately your responsibility to assure that you are complying with IRS rules. The account can also be used to buy non-qualified medical expenses but then the employee is required to pay applicable taxes and a financial penalty to the IRS.

The HSA Administrator (whose contact information including website is listed on the Contact Information Chart in the front of this document) provides 24/7 toll-free access to HSA account services. Additionally, many questions about starting to contribute to an HSA and withdrawing funds from an HSA can be answered by going to the HSA Administrator's website.

THREE TAX SAVINGS OF A HEALTH SAVINGS ACCOUNT (HSA)

Health savings accounts (HSA) provide the HSA account owner with three tax savings:

(a) contributions to an HSA reduce their taxable income,

(b) earnings on the HSA account balance grows tax free and

(c) distributions from an HSA are not taxed for qualified expenses.

Funds in the HSA never expire and can be invested. The HSA is a way to put money aside for short-term health expenses and also as a retirement savings option.

Note that the IRS code was not amended by the Affordable Care Act (ACA) (referred to as Health Reform) regulations to expand the definition of eligible dependents under Health Savings Accounts (HSA) to age 26. This means that you may only be reimbursed from their tax-free HSA accounts for dependent children who meet the Internal Revenue Code definition of tax dependent (qualifying child or qualifying relative), which is a narrower definition than the applicable definition for federal ACA regulations. Money withdrawn from the HSA account for dependent children who are not tax-qualified could cause you to be subject to income tax and a 20% penalty. The HSA participant is responsible for filing and payment of taxes on taxable amounts.

- **Reminder: If your dependent doesn't qualify as a tax deduction (i.e., can't be claimed as a dependent on your tax return), that dependent's expenses are not eligible for reimbursement from your HSA.**

Under the Kern Legacy Select Plan you can contribute to the HSA account (but your employer does not contribute to your HSA account).

Each tax year the IRS announces the maximum amount of money that can be contributed to an individual's HSA account (in 2018 the maximum is $3,450/individual and $6,850/family) and you can contact the HSA Administrator (noted on the Contact Information Chart in the front of this document) each year for the updated information. Individuals age 55 and older can make additional "catch-up" contributions each year (for example, in 2018, the catch-up contributions cannot exceed $1,000). Unused money in the health savings account can grow the account balance because it can be rolled over year after year. The HSA is portable, meaning that the account belongs to you even if you change employers or leave the workforce.

IMPORTANT: In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." IRS guidelines define an HSA Eligible individual as a person who:

- is covered under a HSA-qualified high deductible health plan (HDHP), and
- has "no other health coverage" (except what is permitted by the IRS), and
- is not enrolled in Medicare, and
- cannot be claimed as a dependent on someone else's tax return.

By law, you are not eligible for HSA contributions if you:

- ✓ are enrolled in Medicare (Part A, Part B, Part C -Medicare Advantage Plans, Part D, and Medigap, a Medicare Supplemental Insurance)*,
- ✓ are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- ✓ can be claimed as a dependent on someone else's tax return,
- ✓ are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- ✓ are enrolled in a general purpose Health Care Flexible Spending Account (or covered by a spouse's FSA).

***With respect to being enrolled in Medicare**, HSA contributions generally should be discontinued at least six months prior to filing for Medicare benefits, because Medicare enrollment (called Medicare entitlement) can occur retroactively. If you do not stop HSA contributions six (6) months before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have a tax penalty. The penalty is because you were not supposed to put money into your HSA while you had Medicare coverage. So be sure to stop all contributions to your HSA up to six (6) months before you collect Social Security benefits.

You cannot be covered under your spouse's medical plan or any general purpose Health Flexible Spending Account (Health FSA) that reimburses medical expenses before the deductible is met under the HDHP, a Health Reimbursement Arrangement (HRA), or covered by another plan that pays medical benefits. You could be enrolled in a Dental Plan, Vision Plan, a "limited purpose" Health Flexible Spending Account (Health FSA) that reimburses only dental and vision expenses, or a Dependent Care Flexible Spending Account Plan, and also could have automobile, disability or long-term care insurance coverage.

Individuals who have a health savings account and are enrolled in Medicare can no longer contribute (or have employer contributions made) to the health savings account but can use the money they have accumulated in that HSA account when they were HSA eligible.

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA eligible."

Note about Use of an HSA Account for Dependent Child Expenses: To use funds in a health savings account to reimburse eligible medical expenses for a dependent child, the IRS requires that a HSA account holder must be able to "claim" the child as a dependent on their tax return. If the account holder cannot claim the child as a dependent, then HSA dollars cannot be used to pay for/reimburse services provided to that child. This means that you could cover your 24 year old child on the High Deductible Health Plan but not be able to use funds in your health savings account for that child if the child is not your tax-qualified dependent.

HSA and Domestic Partners: The federal tax rules governing HSAs and domestic partners vary depending on whether the domestic partner is a tax dependent. It is best to consult your tax advisor on whether your domestic partner is a tax dependent.

- **If your domestic partner is a tax dependent**: HSA disbursements from the employee's HSA account for your domestic partner's qualified medical expenses are tax-free. The domestic partner cannot contribute to his or her own HSA. Individuals who can be claimed as dependents on a tax return are not eligible to open their own HSA.
- **If your domestic partner isn't a tax dependent**: HSA disbursements from the employee's HSA account for their domestic partner's medical expenses would be taxable and would also generally be subject to the 20% excise tax. However, there may be situations where the domestic partner may open his or her own HSA and make contributions. It is best to check with the HSA administrator.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you are not certain you will be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you are actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you are enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are considered to be an eligible individual for HSA contributions for the entire tax year and you are not required to prorate your contributions to your health savings account. However, if you base an entire tax year's contribution on your status on December 1 and you cease to be an eligible individual before the end of the following year, any funding of the health savings account over the prorated amount (for December) is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA account. Questions about the High Deductible Health Plan described in this document can be directed to the County's Human Resource Division.

The plan administrator does not provide legal, financial or tax advice and no inference may be made that the information contained here constitutes legal, financial or tax advice. The information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances. The plan administrator assumes no responsibility for the accuracy of tax statements expressed in this document in relation to an individual's tax situation.

MEDICAL EXPENSE BENEFITS

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called an "eligible medical expense." Eligible medical expenses are generally described in the Schedule of Medical Benefits. Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions chapter of this document). The fact that a physician prescribes or orders the service does not, in itself, make it medically necessary or a covered expense; and
2. **not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **not services or supplies in excess of a Maximum Plan Benefit** as shown in the Schedule of Medical Benefits; and
4. ordered by a Physician or Health Care Practitioner **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and
5. **expenses incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have some cost-sharing meaning your will need to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have reached the Out-of-Pocket cost-sharing limit, applicable to deductibles, copayments and coinsurance, no further cost-sharing will apply for the calendar year. The Plan also requires prior authorization (pre-approval) for certain services as explained in the Prior Authorization chapter.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are:

1. not determined to be Medically Necessary,
2. determined to be in excess of the Allowed Charge,
3. not covered by the Plan (whether the service was precertified as medically necessary or not),
4. in excess of a Maximum Plan Benefit or
5. payable on account of a penalty because of failure to comply with the Plan's Utilization Management requirements as described in the Prior Authorization chapter.

NETWORK PROVIDERS

Network providers are Hospitals, Physicians, laboratories, or other providers who have agreed to provide health care services to Plan Members at negotiated rates. The contract agreements are held between the County of Kern and the provider or the provider and the network. All of the medical plans in this document use a network of preferred providers as explained below. See the Contact Information Chart in the front of this document for website access to a free provider director of network providers.

IMPORTANT NOTE

Because providers are added to and dropped from a network periodically throughout the year it is best if you ask the Plan Administrator IF the provider is still participating with your medical plan network, or contact the network each time BEFORE you seek services.

For a list of network providers, see the website of the network located on the Contact Information Chart in the front of this document.

MEDICAL PLAN OPTIONS

This document describes the County's self-funded Medical Plan options. Information on the insured HMO medical plan option is available from the County's Human Resource Division (see the Contact Information Chart in the front of this document). These medical plans provide benefits for preventive medical services, treatment of non-occupational illnesses or injuries and outpatient prescription drugs for covered Members. Some medical plan require the selection of a Primary Care Physician (PCP). The medical plans are described in more detail below and in the Schedule of Medical Benefits.

- **KERN LEGACY SELECT MEDICAL PLAN**: a medical plan designed to be an IRS-qualified high deductible health plan (HDHP) intended to comply with Code §223(c)(2) to allow the County (when applicable) and eligible employees to make contributions to a Health Savings Account (HSA). See the chapter on High Deductible Health Plan (HDHP) with Health Savings Account in this document.

  a) **Network**: This plan **uses the "Select network."** The Select Network offers a listing of Kern Medical specialists providing services through the Kern Medical hospital and offsite medical facilities, as well as locally contracted physicians to provide primary care and specialty care services not provided by Kern Medical. Select Network also includes providers and facilities to service the outlying areas of Kern County. This Plan option is referred to as "Select" because Members must receive care from a selected group of contracted in-network providers. Covered services provided to eligible enrolled Members have low to no copayments after the deductible is met. There is no benefit outside of the Select Network for Members enrolled in Kern Legacy Select Medical Plan unless directed and prior authorized by the Plan or in the case of emergency services performed in an emergency room or the need for an urgent care facility.

  The Select Network providers can be found in the Select Network Provider Directory (available from the County of Kern, County Administrative Office - Human Resources Division (listed on the Contract Information Chart at the front of this document). Members using this Plan must receive all covered services from network providers, except in the case of emergency services obtained in an emergency room.

  b) **Primary Care Physician (PCP):** To receive coverage, a Select Member **must choose a Primary Care Physician (PCP) within the Select Network**. Contact the Plan Administrator (listed on the Contact Information Chart in the front of this document) to select or change a PCP. Family practitioners, general practitioners, internists, OB/GYNs, and pediatricians are all considered to be PCPs.

  The PCP will be responsible for providing or coordinating care within the Network. When specialty care is needed, the PCP will treat the patient or refer the patient to a Select Network Specialist, Hospital or other health care provider.

  If the PCP refers the Member to an out-of-network provider, it is the Member's responsibility to only obtain care in-network in order for services to be considered for Plan coverage. Any requests received by the Plan for authorization of proposed services with an out-of-network provider, will be redirected to in-network providers.

  Exception to the Referral Requirement: A Member is **not required** to obtain a PCP referral to visit an OB/GYN, a specialist for Mental Health or Substance Use Disorder treatment, or for Chiropractic care under the Kern Legacy Select Medical Plan.

  - **However, if a Member seeks treatment from any other Network Specialist without a referral from the PCP, services will not be paid by the Plan.**
  - If this Plan is secondary due to Coordination of Benefits with another plan, PCP referrals are not required.
  - **OB/GYN Providers:** For any treatment other than preventive care and pregnancy related care, under the medical plan OB/GYN providers will be considered to be Specialists and will be subject to the Specialist copay.
  - If the Member's selected PCP is unavailable and the individual requires treatment, the Member may use another contracted network PCP and will receive the Network benefits.

  c) **Emergency Services in an Emergency Room**: Unless previously authorized by the Plan or in the case of emergency services in an emergency room or the need for an urgent care facility, out-of-network services and providers are not covered under the Kern Legacy Select Medical Plan. If the Member receives medical services with an unauthorized out-of-network provider, (except emergency services in an emergency room) the member will be responsible for all charges incurred. There is no coverage for self-referrals to out-of-network providers.

  If the Member receives emergency room or urgent care treatment from a non-network provider, the Member may submit a claim form to the Claims Administrator be considered for reimbursement. Submitting a claim is not a guarantee of payment and is subject to medical review and Plan guidelines.

- **KERN LEGACY NETWORK PLUS MEDICAL PLAN**: a medical plan **using an exclusive provider organization (EPO) network** for the majority of medical services covered, **along with the option to use providers in the Plus network (who are outside the EPO network) for certain covered services,** giving this two-tiered Plan option the name "Network Plus."

  a) **Network:** The Network Plus plan includes access to County-owned Kern Health Care Network providers and contracted facilities, with Kern Medical at the core of the network. The Kern Legacy Network Plus plan has no deductible for the EPO level of benefits but a deductible does apply to the Plus level of benefits. This plan is not a High Deductible Health Plan (HDHP).

Providers for Kern Legacy Network Plus plan can be found in the Kern Legacy Network Plus Provider Directories consisting of the **"EPO"** Network and an additional "**Plus"** Network (previously known as the PPO Network).

1) **"EPO" benefit tier.** The primary benefit referred to as the "EPO" benefit tier, offers a network listing of Kern Medical specialists providing services through the Kern Medical hospital and offsite medical facilities, as well as local physicians to provide primary care and specialty care services not provided by or limited at Kern Medical. This EPO Network also includes providers and facilities to service the outlying areas of Kern County.

   For benefits to be payable in the EPO benefit tier, Members must receive care from an exclusive group of contracted in-network EPO providers which can be found in the EPO Network Provider Directory. Essentially all services needed under this medical plan can be obtained from this EPO benefit tier. Services provided on this EPO benefit tier have low to no copayments therefore, this is the most cost effective benefit of the Kern Legacy Network Plus plan.

2) **"Plus" benefit tier.** Kern Legacy Network Plus plan members can see providers outside the EPO benefit tier and therefore have more options for plan coverage of certain services from contracted providers in the Plus Network (for example these types of providers are in the Plus network: specialists, outpatient rehabilitation services, inpatient hospitals, outpatient surgicenters, laboratory, radiology, and home health care).

   There is a higher out-of-pocket expense associated with services provided through this Plus benefit tier; however, the cost is based on very competitive rates with an out-of-pocket limit making the Plus benefit an affordable option.

   If a Member chooses to consult with a specialist from the Plus Network, the Member can do so on a self-referral basis; however, additional follow-up visits and procedures will require prior approval from the Plan. This Kern Legacy Network Plus plan option allows the flexibility of receiving care outside of the EPO Network at the Member's discretion.

b) **Primary Care Physician (PCP):** To receive coverage, a Network Plus Member must choose a Primary Care Physician (PCP) within the EPO Network. Contact the Plan Administrator (listed on the Contact Information Chart in the front of this document) to select or change a PCP. Family practitioners, general practitioners, internists, OB/GYNs, and pediatricians are all considered to be PCPs.

   The PCP will be responsible for providing or coordinating care within the EPO Network. When specialty care is needed, the PCP will treat the patient or refer the patient to an EPO Specialist, Hospital or other health care provider.

   If the PCP refers the Member to an out-of-network provider, it is the Member's responsibility to only obtain care in-network in order for services to be considered for Plan coverage. Any requests received by the Plan for authorization of proposed services with an out-of-network provider, will be redirected to in-network providers.

   Plus Benefit Tier: The Member also has the choice of using the *Plus Benefit Tier* with the *Plus* network providers. No PCP referral is required for the initial provider consultation. **Services other than the initial consultation will require prior authorization.**

   Exception to the Referral Requirement: A Member is **not required** to obtain a PCP referral to visit an OB/GYN, a specialist for Mental Health or Substance Use Disorder treatment, or for Chiropractic care under the Kern Legacy Network Plus-EPO benefit tier.

   - **However, if a Member seeks treatment from any other Network Specialist without a referral from the PCP, services will not be paid by the Plan.**
   - If this Plan is secondary due to Coordination of Benefits with another plan, PCP referrals are not required.
   - **OB/GYN Providers:** For any treatment other than preventive care and pregnancy related care, under the medical plan OB/GYN providers will be considered to be Specialists and will be subject to the Specialist copay.
   - If the Member's selected PCP is unavailable and the individual requires treatment, the Member may use another contracted EPO Network PCP and will receive the Network benefits.

c) **Emergency Services in an Emergency Room**: Unless previously authorized by the Plan or in the case of emergency services in an emergency room or the need for an urgent care facility, out-of-network services and providers are not covered under the Kern Legacy Network Plus plan. If the Member receives medical services with an unauthorized out-of-network provider, (except emergency services in an emergency room) the member will be responsible for all charges incurred. There is no coverage for self-referrals to out-of-network providers.

If the Member receives emergency room or urgent care treatment from a non-network provider, the Member may submit a claim form to the Claims Administrator be considered for reimbursement. Submitting a claim is not a guarantee of payment and is subject to medical review and Plan guidelines.

- **EPO MEDICAL PLAN**: The Plan is referred to as an exclusive provider organization (EPO for short) because you must receive covered care from a group of specially selected network providers. The Plan's Exclusive Provider Organization (EPO) is a network of Hospitals, Physicians, medical laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide medically necessary covered services and supplies for favorable negotiated discount fees. To locate EPO network providers, see the Contact Information Chart in the front of this document.

  a) **Network:** The County of Kern EPO Network consists of primary care physicians (PCPs) and specialists in two physician groups (GEMCare and DMG) that operate in central California. Both physician groups operate similarly; however, providers in one network may be more convenient to your home or workplace.

  Chiropractic care is available through the MCS Chiropractic network. You don't need a referral from your PCP to take advantage of this benefit. However, the EPO Plan pays chiropractic benefits only for care provided by MCS network chiropractic providers. Prescription drug benefits are administered through NPS (see the Contact Information Chart in the front of this document).

  b) **Primary Care Physician (PCP):** To receive coverage, each EPO Medical Plan Member must choose a Primary Care Physician (PCP) within the EPO Network to manage his or her care. Contact the Plan Administrator (listed on the Contact Information Chart in the front of this document) to select or change a PCP.

  The PCP will be responsible for providing or coordinating care within the EPO Network. Family members are not required to be enrolled in the same medical group and may select different PCPs. Family practitioners, general practitioners, internists, OB/GYNs, and pediatricians are all considered to be PCPs. Your share of the medical costs is lower when your primary care physician (PCP) manages all of your health care; that is, the PCP provides basic health care services, identifies when it's appropriate to consult with a specialist, and refers you to other network specialists when necessary.

  When specialty care is needed, the PCP will treat the patient or refer the patient to an EPO Specialist, EPO Hospital or other EPO health care provider. Specialist referrals will be limited to the physician group you have selected; your PCP will look at all appropriate County of Kern EPO Network specialists.

  If the PCP refers the Member to an out-of-network provider, it is the Member's responsibility to only obtain care in-network in order for services to be considered for Plan coverage. Any requests received by the Plan for authorization of proposed services with an out-of-network provider, will be redirected to in-network providers.

  IMPORTANT: The Plan will not pay benefits for self-referrals to non-network (non-EPO) providers.

  c) **Emergency Care.** The EPO Plan will pay for emergency care when medically necessary – even if a non-network provider performs it. Although you do not need prior referral from your PCP in this situation, it is critical that you contact your PCP as soon as you can after receiving emergency services, regardless of whether the provider is in the network. Your PCP will evaluate your medical situation and make all necessary arrangements to assume responsibility for your continuing care. Once your medical condition is no longer an emergency, you must obtain services from a network provider or your care will not be covered.

  If the Member receives emergency room or urgent care treatment from a non-network provider, the Member may submit a claim form to the Claims Administrator be considered for reimbursement. Submitting a claim is not a guarantee of payment and is subject to medical review and Plan guidelines.

- **POS MEDICAL PLAN**: This Plan is referred to as a Point of Service or POS plan because you get to choose, at the point you need health care services, whether you want to visit a network provider or visit a non-network provider. This POS Medical Plan uses a different network (the Anthem POS network) than applies to the other three medical plan options outlined in this document. The contact information for the POS medical network is listed on the Contact Information Chart in the front of this document.

  a) Providers not contracted as an Anthem POS network provider are considered to be out-of-network providers and out-of-network benfits will apply. The POS Medical Plan is the only medical plan described in this document that contains coverage for both emergency and non-emergency use of out-of-network providers for covered services.

  b) There is no requirement to select a Primary Care Physician (PCP) under the POS Medical Plan and no requirement to obtain a referral for covered services.

  c) Your least out-of-pocket cost occurs when you use the services of a POS network provider.

COST-SHARING (Your Out-Of-Pocket Expenses)

Cost-sharing refers to **how you and the Plan split the cost for covered medical plan benefits**. There are three types of cost-sharing under the Medical Plans outlined in this document: Deductibles, Copayments (called Copays) and Coinsurance. These are explained in more detail below, and on the Schedule of Medical Benefits.

Cost-sharing does not refer to (and you are also responsible to pay) premiums/contributions for coverage, balance billing amounts, or non-covered/excluded medical expenses.

DEDUCTIBLES

The annual deductible (when applicable to the Medical Plan in which you are enrolled) is the amount you must pay each calendar year, toward eligible medical expenses, before the Plan begins to pay benefits. Each calendar year, you (and not the Plan) are responsible for paying your eligible medical expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. There are two types of annual Deductibles: Individual and Family and they are explained on the Schedule of Medical Benefits.

- If a married couple are **both County employees** and cover each other under a County of Kern Medical Plan option, if the Medical Plan has an annual deductible then the Medical Plan's deductibles must be met before the Plan will begin to cover services.
- Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
- Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles, meaning that non-covered expenses or expenses in excess of Allowed Charges cannot be used to satisfy the deductible.
- Copayments, non-covered services, and penalties for failure to obtain prior authorization for services do not accumulate to meet a Deductible.
- The deductible does not apply to preventive services. Acute care (illness & injury) will not be considered preventive care, even if treated during the same visit as a preventive care visit.
- When you are enrolled in the Kern Legacy Select Plan (a HDHP option), this Plan is not permitted to pay ANY benefits (except certain preventive care and certain prescriptions for preventive purposes such as for high blood pressure, high cholesterol, asthma) until your annual deductible has been met. The Select Plan deductible is non-embedded meaning that under family coverage, the total family deductible must be paid before the Plan starts paying for healthcare services (including pharmacy) for any individual member in the family.
- For the POS Plan, when a deductible applies, at least two family members must meet their individual deductible each year before the family deductible is met.

COINSURANCE

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible (when applicable) and paid any copayments (when applicable), the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. The coinsurance related to a covered benefit is described on the Schedule of Medical Benefits.

If you use the services of a Health Care Provider who is a member of the Plan's network (a Network Provider), you will be responsible for paying less money out of your pocket.

COPAYMENT

A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's copayments are indicated on the Schedule of Medical Benefits.

- Copayments are not used to satisfy a Deductible.
- Copayments do accumulate to the annual Out-of-Pocket Limit under the Medical plan options in this document.

OUT-OF-POCKET LIMIT

The annual maximum out-of-pocket limit refers to the most a Member will have to pay in cost-sharing (meaning deductibles, copayment and coinsurance) for covered medical and outpatient prescription drug services during a calendar year. Each time a member has an applicable out-of-pocket expense the money they pay in cost-sharing is applied to an accumulator. Once the annual maximum limit has been accumulated, there will be no additional out-of-pocket expenses for covered services received for the remainder of the calendar year. The accumulator resets every calendar year. The amount of the annual out-of-pocket limit is explained on the Summary of Benefits.

- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- Emergency services performed in an Out-of-Network (non-network) Emergency Room will apply to meet the annual maximum Out-of-Pocket Limit on in-network services.
- In accordance with law, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the Plan's "per person in a family" annual out-of-pocket limit.
- The Out-of-Pocket Limit does not include or accumulate:
  a. Premiums and/or contributions for coverage,
  b. Expenses for medical services or supplies that are not covered by the Medical Plan,
  c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers,
  d. Penalties for non-compliance with Utilization Management program (prior authorization) requirements,
  e. Expenses for the use of non-network providers, except covered emergency services performed in an Out-of-Network Emergency Room,
  f. Charges in excess of a maximum benefit under the Medical Plan, and
  g. Expenses that are not considered to be essential health benefits, such as infertility services.
- There are two Out-of-Pocket Limits under the Kern Legacy Network Plus Plan, the EPO Medical Plan and the POS Medical Plan: one for medical plan expenses that does not include outpatient drugs, and one for outpatient drugs that does not include other medical plan expenses. Together these medical and outpatient drug Out-of-Pocket Limits will not exceed the Out-of-Pocket Limits required by law.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR INDIVIDUALS WITH MEDICARE

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. It has been determined that **the prescription drug coverage is "creditable" for each of the Medical Plans outlined in this document: Kern Legacy Select Plan, Kern Legacy Network Plus Plan, EPO Medical Plan and POS Medical Plan.** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late enrollment penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

> **IMPORTANT NOTE**: If you are enrolled in the **Kern Legacy Select Plan**, a High Deductible Health (HDHP) Plan with the Health Savings Account (HSA) **you may not make contributions to your HSA** once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan. If you want to continue to make contributions to your HSA account, you will not want to enroll in a Medicare Part D plan.

For more information about creditable coverage or Medicare Part D coverage, see the Plan's Medicare Part D Notice of Creditable Coverage (a copy is available from the County of Kern Human Resources Division, at their number located on the Contact Information Chart in the front of this document. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

COVERAGE OF CERTAIN OVER-THE-COUNTER (OTC) AND PRESCRIPTION DRUGS MANDATED BY THE AFFORDABLE CARE ACT (ACA)

ACA Mandated Drugs: In accordance with ACA, certain over-the-counter (OTC) and prescription drugs are payable at no charge when prescribed and filled at a network pharmacy. No coverage for ACA mandated drugs from a Non-Network pharmacy. Covered drugs include, for example:

a. FDA-approved contraceptives for females: 100%, no cost-sharing for generic contraceptives submitted with a prescription purchased at a network Retail location only. There is no charge for a brand prescription contraceptives only if a generic

contraceptive is unavailable or medically inappropriate (the attending provider determines medical necessity for FDA-approved female contraceptives).

b. Tobacco/smoking cessation benefit: Coverage is extended for over-the-counter or prescription FDA-approved tobacco cessation products (such as nicotine gum or patches) or programs intended to assist an individual to stop smoking or using tobacco products These are payable at no cost when you present a written prescription from a Physician to a network pharmacy. See also the Behavioral Health row of the Schedule of Medical Benefits for tobacco cessation counseling support.

c. Certain Drugs to Reduce the Risk of Breast Cancer (generic tamoxifen or aloxifene) are payable at no charge at a network pharmacy for women who are at increased risk of breast cancer and low risk for adverse medication effects.

For an over-the-counter or prescription drug listed below to be covered by the Plan, the drug must be:

1. obtained through the outpatient Prescription Drug Program at a participating network retail or mail order pharmacy and
2. presented to the pharmacist with a prescription for the drug from your Physician or Health Care Practitioner.

The following chart outlines certain OTC and prescription drugs that are payable by the non-grandfathered medical plans in this document in accordance with ACA regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations, **at no charge when filled at a network pharmacy**.

Where the information in this document conflicts with newly released ACA regulations affecting the coverage of OTC and prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
FDA-approved Contraceptives for females, such as birth control pills, spermicidal products and sponges.	All females	None, if payment parameters are met	FDA-approved contraceptives are payable under the plan's Prescription Drug Program. Generic FDA-approved contraceptives are at no cost to the plan participant. Brand contraceptives are payable if a generic alternative is medically inappropriate, as determined by the Physician or Health Care Practitioner.
Aspirin	• For men 45-79 years of age to reduce chance of a heart attack. • For women 55-79 years of age to reduce the chance of a stroke. • For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	For non-pregnant adults: since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Folic acid supplements	All females planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	None, if payment parameters are met	Plan covers generic folic acid up to one tablet per day. Excludes women over 55 years of age, and products containing more than 0.8mg or less than 0.4mg of folic acid.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the plan's Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all FDA-approved products. No prior authorization is required. See also the Behavioral Health row of the Schedule of Medical Benefits for tobacco cessation counseling support.
Fluoride supplements	For children starting at age 6 months when recommended by a provider because the child's primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a screening colonoscopy for individuals age 50-75 years.
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive drugs such as tamoxifen or aloxifene.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The Kern Legacy Select Plan, the Kern Legacy Network Plus Plan and the EPO Medical Plan **generally require the designation of a primary care provider (PCP)**. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician (including pediatric subspecialties) as the primary care provider, if provider is accepting patients.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator associated with the medical plan in which you are enrolled (see the Contact Information Chart in the front of this document).

The POS Medical Plan does not require designation of a primary care provider (PCP).

You do not need prior authorization or an approved referral from your PCP, the Plan or from any other person to obtain care from a network OB/GYN. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating (network) health care professionals who specialize in obstetrics or gynecology, contact your medical plan network (see the Contact Information Chart in the front of this document.)

NONDISCRIMINATION IN HEALTH CARE

In accordance with Section 2706(a) of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's Medical Benefits, appears on the following pages in a chart format. **There is one Schedule to describe the Kern Legacy Select and Kern Legacy Network Plus plan options and a separate Schedule to describe the EPO and POS Medical Plan options.**

In the Schedule, each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use Network Providers) and Out-of-Network (when you use Non-Network Providers) are shown in the subsequent columns.

In the Schedule of Medical Benefits you will note that Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed in the first few rows because these categories of benefits apply to most (but not all) health care services covered by each Medical Plan. These rows are followed by descriptions, appearing in **alphabetical** order, of the other covered medical benefits along with any limitations and exclusions to those covered benefits.

All benefits shown in the Schedule of Medical Benefits are subject to the Plan's annual Deductible unless there is a specific statement that the deductible does not apply or the Medical Plan does not have an annual Deductible.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions chapter of this document to see if they are excluded.

Several factors affect the Member's receipt of the benefits described in the Summary of Medical Benefits Chart: the Member must be properly enrolled and have coverage that is effective at the time of service, and receive care that is not limited by any exclusions.

If you are unsure about a particular medical expense, to avoid unexpected out-of-pocket expenses, be sure to contact the County of Kern Human Resource Division (see the Contact Information Chart in the front of this document).

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within ONE YEAR from the date of service. No Plan benefits will be paid for any claim submitted after this period.

See also the Claim Filing and Appeal Information chapter for more information. Also, review the section toward the end of that chapter on "Limitation On When A Lawsuit May Be Started."

How can I be a wise consumer of health care and get the most value out of my Medical Plan?

- ✓ **Use Network providers.** They charge less, and you pay less. In addition, Preventive Care is free when provided by Network providers.
- ✓ **Choose Generic drugs and use the Mail Order Service when possible.** Ask your Doctor if a generic drug is appropriate for you. You will pay less for generic drugs than for brand name drugs in most situations.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range), get tips from your provider on how to reduce your health risks, and stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your Network Doctor's office for help. Or, use a Network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Seek Prior Authorization** of your elective hospital admission, certain outpatient drugs, and a variety of outpatient services, as explained in the Prior Authorization chapter, to help avoid a financial penalty.
- ✓ **Review Your Medical Bills.** If something on a medical bill just doesn't look right, contact the Medical Plan Claims Administrator if you think there might be an error on a bill.

These tips will help you make the most of your medical plan benefits.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Deductible
• The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits.
• Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
• Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles.
• Copayments do not accumulate to meet the deductible.
• The deductible applies to all covered services except where otherwise noted in this Schedule of Medical Benefits.
	• **SPECIAL NOTE WHEN ENROLLED IN THE SELECT (HDHP) PLAN**:
	  • In accordance with IRS requirements, **this HDHP Plan is not permitted to pay ANY benefits until your annual deductible has been met** (except certain preventive care and certain prescriptions for preventive purposes such as for high blood pressure, high cholesterol, asthma).
	  • The Select Plan **deductible is non-embedded** meaning that under family coverage, the total family deductible must be paid before the Plan starts paying for healthcare services (including pharmacy) for any individual member in the family.
	• **SPECIAL NOTE WHEN ENROLLED IN THE NETWORK PLUS PLAN**: The Plus Benefit Tier has an embedded deductible meaning that under family coverage, each Member of the family has an individual deductible in addition to the whole family deductible. This means that when a covered family Member meets the individual deductible, the Plan will began to pay for covered services associated with qualified medical expenses from Plus network providers for that individual Member. The remaining family deductible will have to be met before the Plan will begin to pay for covered services for the other family members. Once two Members of the family meet their individual deductible, the family deductible will be satisfied for the calendar year and coverage will begin on the Plus benefit tier for all Members of the family.
		$2,000
		per person
		
		$4,000
		per family
			No deductible applies to this EPO Tier	$250
				per person
				
				$250 per person in a family
				
				$500
				per family

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year year) before your medical plan starts to pay 100% for covered essential health benefits received from Network providers. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit. • In accordance with law, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, **no one individual in the family will be required to accumulate more than the Plan's "per person in a family" annual out-of-pocket limit.**	**The Medical Plan Out-of-Pocket Limit does not include or accumulate:** a) Premiums and/or contributions for coverage, b) Expenses for medical services or supplies that are not covered by the Medical Plan, c) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers, d) Penalties for non-compliance with Utilization Management program (prior authorization) requirements, e) Expenses for the use of non-network providers, except covered emergency services performed in an Out-of-Network Emergency Room, f) Charges in excess of a maximum benefit under the Medical Plan, and g) Expenses that are not considered to be essential health benefits, such as infertility services. • Under the Kern Legacy Network Plus Plan, expenses for outpatient drugs (these accumulate to a **separate outpatient drug Out-of-Pocket Limit**. There are two Out-of-Pocket Limits under the Kern Legacy Network Plus Plan: one for medical plan expenses that does not include outpatient drugs, and one for outpatient drugs that does not include other medical plan expenses. Together these medical and outpatient drug Out-of-Pocket Limits will not exceed the Out-of-Pocket Limits required by law	The following out-of-pocket limit includes both medical plan and outpatient drug benefits: $6,000 per person $6,000 per person in a family $12,000 per family	The following out-of-pocket limit includes medical plan benefits only: $1,000 per person $1,000 per person in a family $2,000 per family. The Kern Legacy Network Plus Plan's out-of-pocket limit for outpatient prescription drugs is: $1,600 per person; $1,600 per person in a family $3,200 per family.	The following out-of-pocket limit includes medical plan benefits only: $4,000 per person $4,000 per person in a family $8,000 per family.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. Be sure to properly enroll your newborn if you want coverage under the County's medical plan for that child.	• **Elective Hospitalization requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Private room is covered when Medically Necessary or if the facility does not provide semi-private rooms. • Under certain circumstances, the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if this Plan determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. This medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a hospital or outpatient surgery facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • **Newborn care**: Medically Necessary expenses incurred by an eligible, enrolled newborn infant including services and supplies furnished by a Hospital and by a Physician to care for the newborn infant during initial Hospital confinement. Inpatient Physician care includes, but is not limited to, examinations and the circumcision of male infants. See the Eligibility provisions (in a separate document) for how to properly enroll Newborns so coverage can be considered. • 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 deductible for non-network providers will be waived for the infant only. • **Admission from an Emergency Room Visit**: If you visit the emergency room of a non-network hospital and require admission to that non-network hospital, the Plan will pay the claims for covered services related to the admission at the preferred network level of benefits. When stable, if you need continued hospitalization, the Plan will facilitate your transfer to an in-network facility to complete the treatment. The emergency visit to the emergency room of a non-network hospital will be paid in accordance with law as discussed in the definition of Allowed charge in this document.	**Kern Medical facility**: After deductible met, you pay $100 copay/day up to $500/admission. **Other Select Network facility:** After deductible met, you pay $100 copay/day up to $500/admission. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** After deductible met, you pay $100 copay/day up to $500/admission.	**Kern Medical facility**: No charge (100% Plan coverage). **Other EPO Network facility:** You pay $100 copay/day up to $500/admission. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** You pay $100 copay/day up to $500/admission.	**Kern Medical facility**: Services are covered when using the EPO tier. **Other Plus Network facility:** After deductible met, you pay 20%. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** Services are covered when using the EPO tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center, patient's home, or other covered health care facility location. Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if Medically Necessary)
  • Anesthesia by Physicians & Certified Registered Nurse Anesthetists (CRNA)
  • Hospitalists, Pathologist, Radiologist
  • Podiatrist (DPM), Physician Assistant; Nurse Practitioner; Certified Nurse Midwife
• Medically necessary injections and professional services to inject the medication are covered.
• See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from Network providers. See also the Emergency Services row for payment of providers in an emergency room.
• Eye examination and hearing examination is covered to determine the need for correction of vision and hearing.
	• **Certain Physician & Health Care Practitioner services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure. See also the definition of Physician, Health Care Practitioner in the Definitions chapter.
	• **Assistant Surgeon fees** will be reimbursed for Medically Necessary services to a maximum of 18.4% of the eligible expenses allowed for the primary surgeon.
	• **Primary Care Physician (PCP)** means a Physician or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology. All other Physicians are considered specialists under this Plan. Health Care Practitioners under contract to a network provider, such as a nurse practitioner, certified nurse midwife, physician's assistant or therapist are also payable providers. In accordance with law, there is no requirement to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• **Routine Foot Care Benefit**: Routine foot care administered by a licensed medical professional including a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• The Plan **does not cover**: non-surgical treatment of toe/foot deformities, routine foot care for treatment of corns, calluses, clipping of toenails, flat feet, fallen arches, weak feet, chronic foot strain, and asymptomatic complaints related to the feet. This exclusion does not apply when related to treatment of the foot secondary to diabetes or a neurological or vascular insufficiency affecting the feet. See also the Corrective Appliances row.
	• Blepharoplasty (surgical modification of the eyelid) is covered if deemed medically necessary by the Plan, but is not covered for cosmetic reasons such as lower eyelid blepharoplasty to improve puffy eyelid "bags" and/or to reduce the wrinkling of skin. **Prior authorization is required**.
	• Chelation therapy (a process of binding a substance) is covered when medically necessary (such as for treatment of heavy metal poisoning). **Prior authorization is required**.
		PCP visit: After deductible met, $10 copay/visit.
		Specialist visit: After deductible met, $20 copay/visit.
		Preventive Care Visits with PCP or Specialist: No charge, deductible does not apply.
		Provider services during inpatient admission or outpatient surgery: After deductible met, no charge.
			PCP visit: $10 copay/visit.
			Specialist visit: $20 copay/visit.
			Preventive Care Visits with PCP or Specialist: No charge.
			Provider services during inpatient admission or outpatient surgery: No charge.
				PCP visit: Services covered when using the EPO Tier.
				Specialist visit: After deductible met, you pay 20% coinsurance.
				Preventive Care Visits with PCP or Specialist: Services covered when using the EPO Tier.
				Provider services during inpatient admission or outpatient surgery: After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Allergy Services	• **Allergy testing and allergy injections/shots (immunotherapy) services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	Allergy Testing, Allergy Shots, and Allergy Antigen performed when an office visit is billed is payable like a Physician office visit. See the Physician and Other Health Care Practitioners Services row. If an office visit is not billed to the Plan then there is no cost to the member for the allergy testing or allergy shots/antigen. Allergy testing performed by a laboratory is payable in accordance with the Laboratory services row of this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Ambulance Services for Medical Emergency
• **Ground vehicle emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness/injury;
  • for Medically Necessary **non-emergency medical transportation** such as inter-health care facility transfer (e.g. transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a special test/procedure).
• **Air/sea emergency transportation** is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition.
	Expenses for ambulance services are covered only when those services are for an **Emergency,** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-health care facility transport. Medically Necessary ambulance services are covered when one or more of the following criteria are met.
	a) Transportation is by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured; and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water/sea, fixed wing, and rotary wing air transportation.
	b) **For ground ambulance, member is taken:**
	- From home, the scene of an accident or medical Emergency to a Hospital;
	- Between Hospitals, including when the Plan requires transfer from an Out-of-Network to a Network Hospital;
	- Between a Hospital and a Skilled Nursing Facility or other approved Facility.
	c) **For air or sea/water ambulance, member is taken:**
	- From the scene of an accident or medical Emergency to a Hospital;
	- Between Hospitals, including when the Plan requires transfer from an Out-of-Network to a Network Hospital;
	- Between a Hospital and an approved Facility.
	Air ambulance will not be covered if the Member is taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if the Member is taken to a Physician's office or home.
	Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if the member is not taken to a facility.
	Emergency ambulance services do not require prior authorization.
	• **Ambulance and non-emergency transportation services are not covered when**:
	a) Another type of transportation can be used without endangering the member's health.
	b) For convenience of the member or the convenience of the family or doctor
	c) For trips to a Doctor's office or clinic, a morgue or funeral home.
	• **Non-emergency medical transportation** refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. Non-Emergency ambulance or medical transportation services deemed Not Medically Necessary by the Plan are not covered.
	• **Non-emergency medical transportation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
		Emergency Transport: After deductible met, no charge.
		Non-emergency medical transport: After deductible met, no charge.
			Emergency Transport: No charge.
			Non-emergency medical transport: No charge
				Emergency Transport and **Non-emergency medical transport:** Services covered when using the EPO Tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.			
Bariatric Surgical Services • Initial surgery and repeat surgery is covered as outlined to the right. • See also the definitinon of Morbid Obesity.	• **Initial Bariatric Surgical Procedure:** is covered if the member has been compliant with the Physician's required weight management program and the procedure has been prior authorized by the Plan. **Requirements:** a) Must be 18 years or older. b) Must meet the body mass index (BMI) criteria for morbid (extreme) obesity as established by the National Institute of Health. NOTE: BMI can be calculated using the National Heart, Lung and Blood Institute website: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm and https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_dis.htm. c) Documented failure of prior non-invasive attempts at weight loss. d) Evidence of member completing, a six (6) month physician supervised weight loss program. e) Clearance by a mental health professional to determine psychological suitability for bariatric surgery and rigorous postoperative regimen. f) Nutritional assessment and preoperative counseling for post-operative dietary management. • **Repeat Bariatric Surgical Procedure:** is covered under the following circumstances: a) There is a complication related to the initial bariatric surgery that requires modification of the original surgical site (i.e. stricture or obstruction). b) The member met criteria for the initial bariatric procedure and had not lost weight in the first two post-surgical years to lower the BMI at least 10 units (BMI is expressed in units of kg/m^2 not in pounds). c) A repeat clearance by a mental health professional will be required to determine psychological suitability for repeat bariatric surgery and rigorous postoperative regimen. • Bariatric Surgical Procedures are **limited to a lifetime maximum of two bariatric surgical procedures**. • **Bariatric surgery services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Procedures to remove excess skin after weight loss, including panniculectomy, are not a covered benefit, unless determined by the Plan to be medically necessary.	See the Hospital and Physician services rows in this Schedule.	See the Hospital and Physician services rows in this Schedule.	See the Hospital and Physician services rows in this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **Employee Assistance Program (EAP) Services:** This plan offers EAP visits at no cost to you for professional confidential counseling. The phone number for the EAP program is listed on the Contact Information Chart in the front of this document. In addition to the EAP services the following benefits are available: • **Inpatient acute hospital admission, or residential treatment program.** See the Definitions chapter for the meaning of the term residential treatment. • **Outpatient visits** including crisis intervention, counseling, medication management and necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services**: partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Definitions chapter for the meaning of the term partial day care and intensive outpatient program. • Screening for tobacco use. For those who use tobacco products, the Plan covers tobacco cessation support described to the right.	• For assistance locating behavioral health providers best qualified to treat your needs please contact the Plan Administrator for your medical plan (See the Contact Information chart in the front of this document). • **Elective inpatient admission to an acute hospital for mental health or substance abuse treatment, admission to a residential treatment program, partial hospitalization and an intensive outpatient program requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Behavioral Health **residential treatment program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. **Prior authorization is required for admission and drug testing**. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • The Behavioral Health benefits of this Plan may be used for smoking/tobacco cessation counseling. **Tobacco Cessation support**: The Plan covers, at no cost from Network providers, at least two tobacco cessation attempts per person per year. A cessation attempt includes coverage for four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling) (without Prior Authorization). FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) are covered at no cost from Network retail pharmacy locations for a 90-day treatment regimen when prescribed by Physician or Health Care Practitioner (without prior authorization). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • Court ordered mental health and/or substance use disorder treatment is covered to the extent the treatment is a covered benefit and is medically necessary. • See the specific exclusions related to Behavioral Health Services, in the Exclusions chapter. Applied Behavior Analysis (ABA) Therapy is not a covered benefit.	**EAP Visits and Tobacco Cessation Counseling:** No charge. **Outpatient visits:** After deductible met, $10 copay/visit **Other Outpatient Services:** After deductible met, $10 copay/visit **Inpatient Hospital at Kern Medical facility or Other contracted facility**: After deductible met, you pay $100 copay/day up to $500/admission. **Residential Treatment Program:** After deductible met, you pay $100 copay/day up to $500/admission.	**EAP Visits and Tobacco Cessation Counseling:** No charge. **Outpatient visits:** $10 copay/visit **Other Outpatient Services:** $10 copay/visit **Inpatient: Hospital:** $100 copay/day up to $500/admission. **Residential Treatment Program:** $100 copay/day up to $500/admission.	Services are covered when using the EPO tier.
Birthing Center	• See also the definition of Birthing Center in the Definitions chapter.	Birthing Center services payable according to the Hospital row of this Schedule.	Birthing Center services payable according to the Hospital row of this Schedule.	Services are covered when using the EPO tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Blood Transfusions • Blood transfusions including blood processing, the cost of blood, unreplaced blood and blood products and equipment for its administration.	• Expenses related to autologous blood donation (patient's own blood) are covered for elective surgery.	After deductible met, no charge.	No charge.	After deductible met, you pay 20% coinsurance.
Chemotherapy • A regimen comprised of a single agent or a combination of agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs. • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Chemotherapy Drugs are payable for: a) Use that is included as an indication on the drug's label as approved by the FDA. b) Use of an FDA-approved drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major drug compendia, medical literature, and/or accepted standards of medical practice. c) Use of drugs to treat toxicities or side effects of the cancer treatment regimen when the drug is administered in relation to chemotherapy, including off-label uses supported by medical literature. • Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home (see Home Health care) or in a Physician's office, see Physician's and Other Health Care Practitioners (above) in this Schedule of Medical Benefits. • One wig is payable up to $3,000/person per lifetime, for hair loss following chemotherapy or radiation therapy.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.
Chiropractic Services	• Includes initial evaluation and chiropractic manipulation to a **maximum of 20 visits/calendar year**.	After deductible met, you pay $10 copay/visit.	You pay $10 copay/visit.	After deductible met, you pay 20% coinsurance.
Contraceptives	• See Family Planning row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Corrective Appliance is the general term for: Internal/external prosthetic devices (devices to replace a missing body part) and Orthotics (devices to support a weakened body part, such as a back brace) and are covered when Medically Necessary as determined by the Plan through the prior authorization process.
• Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows:
  • rental (but only up to the allowed purchase price of the device).
  • purchase of standard model. Rental or purchase determined by the Plan Administrator or its designee.
  • repair, adjustment or servicing of the device when Medically Necessary.
  • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Colostomy, ostomy and/or urinary catheter supplies.
	• **Prosthetic and Orthotic services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
	• **Internal prosthetics**: The following, when Medically Necessary and surgically implanted; are covered, including but not limited to:
	  • Electronic heart pacemakers, intraocular lenses, and joint replacements
	  • Breast implant related to reconstruction following a mastectomy.
	• **External prosthetics**: The following, when Medically Necessary, are covered:
	  • Artificial limbs or eyes including the initial purchase and replacements due to physical growth. Artificial limbs are limited to standard items and must be adequate to provide a reasonable level of functionality for normal daily activities.
	  • Breast prostheses following a mastectomy.
	• Prosthetic devices will be replaced when they are no longer functional due to normal wear or physical growth. However, the repair or replacement of a device that has been lost or misused is not covered.
	• One eye examination and one pair of eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye such as with a cataract extraction. Sunglasses are not covered.
	• **Orthotics**: The Plan covers medically necessary orthotic devices, such as a back or knee brace, or cervical collar.
	  a) **Non-Foot Orthotics,** such as a back brace or knee brace, are payable when medically necessary, including necessary supplies, repair and servicing. A custom-made orthotic device is payable where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off-the-shelf) orthotic device.
	  b) Foot orthotics are not covered, except for **Podiatric (foot) appliances** for prevention of complications of diabetic nerve conditions, (limited to one (1) pair per calendar year). Foot orthotics that are not incorporated into a cast, splint, brace or strapping of the foot are not covered. Also one pair of **diabetic shoes** is covered per calendar year.
	• For information on hearing exams and hearing aids, see the Hearing row in this Schedule.
	• See these other rows: Non-durable Supplies, Durable Medical Equipment.
	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.
		Eyeglasses or contact lenses after surgery to remove the lens of the eye: After deductible met, Plan pays 100% up to $150/frame or lenses.
		
		All other Corrective Appliances: After deductible met, no charge
			Eyeglasses or contact lenses after surgery to remove the lens of the eye: Plan pays 100% up to $150/frame or lenses.
			
			All other Corrective Appliances: No charge.
				Eyeglasses or contact lenses after surgery to remove the lens of the eye: After deductible met you pay 20% coinsurance.
				
				All other Corrective Appliances: After deductible met you pay 20% coinsurance.

Dental Services	• See the Oral services row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Diabetes Self-Management Education	• Training and education for self-management of diabetes is covered. • For information on diabetes supplies see the Durable Medical Equipment row and the Drug row.	No charge. Deductible does not apply.	No charge.	After deductible met, you pay 20% coinsurance.
Dialysis • Plan covers dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic renal disease is covered. • Plan covers hemodialysis or peritoneal dialysis (and supplies administered). Plan covers hospital-based, outpatient dialysis centers or home dialysis and training in the operating of dialysis equipment, including supplies for and maintenance of dialysis equipment used in a Member's home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **Dialysis services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • When you have reached end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. **It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible. **Medicare and ESRD:** Once you are eligible for Medicare, you must apply for enrollment in Medicare. If the application for enrollment is accepted, Medicare coverage may begin. Medicare coverage begins at different times for different people depending on the circumstances. Medicare coverage usually starts the first day of the 3rd month after the month in which a course of regular dialysis begins. All, or a portion of, the 3-month waiting period may be waived if you participate in a self-dialysis training program, or if you have a kidney transplant within the 3-month waiting period. **When you are on dialysis and covered by both Medicare and this group health plan, for the first 30 months (referred to a 30-month coordination period), your group health plan is the primary payer of your dialysis and other covered medical services.** It is important to note that the 30-month coordination period always begins on the date you are first eligible to enroll in Medicare due to ESRD. If for example, you fail to submit a timely application for Medicare or chooses not to apply for Medicare, the 30-month coordination period will be calculated with a start date based on the month in which you could have been enrolled, had you made an application for Medicare. Medicare becomes the primary payer of benefits after the 30-month coordination period ends, as long as you retain Medicare eligibility based on ESRD. A Medicare beneficiary may have more than one 30-month coordination period. Medicare entitlement (meaning eligibility and coverage under Medicare) because of ESRD, will end if you have not received dialysis for 12 months or if 36 months have passed since you had a successful kidney transplant. For more information on Medicare see your **"Medicare and You" Handbook** or https://www.medicare.gov/people-like-me/esrd/esrd.html or https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Dietitian/Nutrition Services	• Certain dietary counseling may be payable as a Preventive Care (wellness) service in accordance with ACA requirements. As a **preventive counseling benefit** in compliance with ACA, the Plan covers the following services: for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to **intensive behavioral counseling interventions** to promote a healthful diet and physical activity for CVD prevention.	Preventive Counseling Benefit: No charge. Deductible does not apply.	Preventive Counseling Benefit: No charge.	Covered when using the EPO Tier.

duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Coverage is provided for prenatal vitamins, drugs required to be covered due to ACA, FDA-approved female contraceptives, insulin & syringes, and diabetic blood glucose testing supplies such as lancets, teststrips, etc.
• Most over-the-counter (OTC) non-sedating antihistamines, like Claritin and proton pump inhibitors like Prilosec are covered when prescribed by a network provider.
• Contact the Prescription Benefit Manager (PBM) for the following:
  • The list of drugs on the **Preferred Drug formulary**.
  • Information on **drugs needing prior authorization** (pre-approval) by the clinical staff of the Prescription Benefit Manager (PBM), such as specialty drugs or off label drug use.
  • Information on which **drugs have a limit to the quantity** payable by this Plan.
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug option.
	monitoring and are used by individuals with unique or chronic conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, cancer or hepatitis. These drugs **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity.
	• Covered outpatient prescription drugs do accumulate to meet the annual Out-of-Pocket Limit. Copayments for drugs do not accumulate to meet the Plan's Deductible(s)
	• **ACA mandated drugs** (such as FDA-approved female contraceptives, certain over the counter medications and tobacco cessation products) are covered at no charge. See page 21 for information on ACA mandated over the counter medications and prescription drugs.
	• Certain **CDC recommended preventive care immunizations/vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Prescription Benefit Manager for more information.
	• **For the Select HDHP Plan**: For a list of drugs that are considered to be "HDHP Preventive Generic Drugs," contact the Prescription Drug Program (see the Contact Information Chart in the front of this document).
	• Kern Medical Affiliated Network offers programs to help manage certain conditions, **free workplace desk delivery services**, and free FedEx deliveries to your residence to make getting your prescriptions more convenient. Also, Kern Medical participates in the 340B Drug Pricing Program which requires drug manufactures to provide outpatient drugs at a significantly reduced price as long as certain required criteria is met, which means reduced copays for you for drugs purchased at a Kern Medical Affiliated Network pharmacy. Some drugs can only be purchased at a Kern Medical Affiliated Network pharmacy, such as some specialty medications.
	• The Plan covers drugs which are prescribed by a dentist for dental care.
	• Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will not be covered until and unless a clinical review and formulary placement has been made by the Prescription Benefit Manager (PBM).
	• The drug benefits under these medical plans are "creditable" with Medicare. Creditable means the value of the medical plan drug benefit is expected to pay out as much as the standard Medicare Part D prescription drug plan will allow.
	• No coverage for male contraceptives, over-the-counter (OTC) medications except the Plan covers drugs required by ACA, fertility drugs, growth hormones, compound drugs, and anabolic steroids. See also the exclusions related to Drugs (Medicines) in the Exclusions chapter and the definition of "Experimental and/or Investigational" in the Definitions chapter.
		supplies: No charge, deductible does not apply.
		HDHP Preventive Generic Drugs:
		$0 copay, deductible does not apply.
		Kern Medical Affiliated Network Pharmacy, non-specialty drugs 90-day supply, after deductible:
		- **Generic:** $0 copay
		- **Preferred Brand:** $25 copay
		- **Non-preferred Brand:** $50 copay
		Kern Medical Affiliated Network Pharmacy, Specialty drugs 30-day supply, after deductible:
		- **Generic:** $50 copay
		- **Preferred Brand:** $90 copay
		- **Non-preferred Brand:** $120 copay
		NON-Kern Medical Pharmacy 30-day supply, after deductible:
		- **Generic:** $5 copay
		- **Preferred Brand:** $50 copay
		- **Non-preferred Brand:** $90 copay
			Diabetes drugs and supplies: No charge.
			Kern Medical Affiliated Network Pharmacy, non-specialty drugs 90-day supply, and specialty drugs for 30-day supply:
			- **Generic:** $0 copay
			- **Preferred Brand:** $15 copay
			- **Non-preferred Brand:** $35 copay
			NON-Kern Medical Pharmacy 30-day supply:
			- **Generic:** $5 copay
			- **Preferred Brand:** $30 copay
			- **Non-preferred Brand:** $60 copay
				No deductible applies to outpatient drugs.
				Services are covered when using the EPO tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Durable Medical Equipment (DME)
• Coverage is provided for Medically Necessary DME including oxygen, along with the medically necessary equipment and supplies required for oxygen administration, diabetic blood glucose meter and other medically necessary diabetes durable medical equipment. Coverage is provided for:
  • rental (but only up to the allowed purchase price of the Durable Medical Equipment). Rental of DME items may not become the property of the Member and must be returned to the DME provider when no longer needed or upon termination of the Member's coverage, whichever occurs first. If the equipment is not returned by the Member or returned in poor condition, the Member may be responsible for the replacement or repair cost unless the purchase price has been paid by the Plan;
  • purchase of standard model equipment. Rental or purchase determined by the Plan Administrator or its designee;
  • repair, adjustment or servicing of Medically Necessary DME;
  • replacement of Medically Necessary Durable Medical Equipment is when medically necessary (e.g. if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense).
	• **Certain Durable Medical Equipment requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
	• Durable Medical Equipment (and supplies necessary for the function of the durable medical equipment) is covered when medically necessary and prescribed by a Physician.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. For prosthetics and orthotic devices, see the Corrective Appliances row of this Schedule. For disposable medical supplies, see the Non-durable supplies row.
	• For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies necessary to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable as outlined to the left.
	• Diabetes insulin pump and diabetes glucose meter and supplies needed to operate these devices are covered. Disposable diabetes supplies like test strips, lancets, insulin pen, syringes, injection aids and devices for the visually impaired diabetic are payable under the outpatient Drug benefit.
	• The following equipment is not covered:
	  a) Items obtained without a physician order.
	  b) Items that are deemed personal comfort items (i.e. humidifiers and bath/shower seats).
	  c) Exercise equipment, sports equipment, equipment intended to enhance athletic ability and hygienic equipment.
	  d) More than one DME device designed to provide essentially the same functional assistance.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter.
		Breast pump and supplies necessary to operate pump: No charge. Deductible does not apply.
		
		Other DME: No charge after deductible met.
			Breast pump and supplies necessary to operate pump: No charge.
			
			Other DME: No charge.
				Breast Pump and supplies necessary to operate pump: Services are covered when using the EPO tier.
				
				Other DME: After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Education Services	• Patient education to help manage health risks and/or conditions.	No charge. Deductible does not apply.	No charge.	After deductible met you pay 20% coinsurance.

Emergency Room Facility, Urgent Care Facility
• Coverage is provided for:
  • a **hospital emergency room (ER)** visit for "emergency services" (as that term is defined in this Plan).
  • **Urgent Care** facility visit.
  • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit.
• The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an emergency room or urgent care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.
• See also the Ambulance row of this schedule.
	• **Emergency room:** The visit copayment will be waived if subsequent immediate hospitalization is required. See the Hospital row if you are admitted because of your emergency room visit.
	• In accordance with law, there is **no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit**.
	• Although members do not need prior referral from a PCP in an emergency situation, **members must contact their PCP as soon as possible (preferably within 48 hours) after receiving emergency or urgent care services** to ensure coordination of future treatment needs. The PCP will evaluate the medical situation and make all necessary arrangements to assume responsibility for continuing care.
	Once discharged from the emergency room or urgent care facility, in order for benefits to be payable by the Plan, the Member must obtain follow-up services from a contracted network provider or the care will not be covered.
	• Examples of common conditions treated in an emergency room or urgent care facility:
	COMMON CONDITIONS TREATED IN AN EMERGENCY ROOM (ER)
	▪ chest pain or heart attack ▪ seizure or head injury ▪ other major trauma
	▪ difficulty breathing ▪ severe bleeding ▪ loss of consciousness
	▪ stroke ▪ poisoning/overdose ▪ sudden loss of vision or blurred vision
	COMMON CONDITIONS TREATED IN AN URGENT CARE FACILITY
	▪ minor burn or injury ▪ ear infection or sinus infection ▪ allergic reactions (non-life threatening)
	▪ sprain, strain, broken bone ▪ mild asthma or bladder infection ▪ fever or flu-like symptoms or migraine
	▪ cough, cold, sore throat ▪ animal bites ▪ rash or other skin irritations
	• The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.
		Emergency Room (ER) visit for emergency services (in-network or out-of-network): After deductible met, you pay a $150 copay/visit.
		Urgent Care Facility visit: After deductible met, you pay a $15 copay/visit
			Emergency Room (ER) visit for emergency services (in-network or out-of-network): You pay a $150 copay/visit.
			Urgent Care Facility visit: You pay a $15 copay/visit
				Emergency Room (ER) visit for emergency services (in-network or out-of-network): Services are covered. Same cost-sharing as when using the EPO tier.
				Urgent Care Facility visit: Services are covered when using the EPO tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Endoscopy Facility (Outpatient)	• See the outpatient surgery row of this schedule. • Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs (bronchoscopy), intestines (colonoscopy), bladder (cystoscopy), stomach (gastroscopy), etc.	See the outpatient surgery row of this schedule.		
Family Planning, Contraceptives, Infertility, and Erectile Dysfunction Services • Coverage is provided for ACA mandated preventive service FDA-approved **female contraceptives** such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive drug coverage. • **Sterilization services** (e.g., vasectomy, tubal ligation, tubal implants such as Essure). • **Fertility/infertility** services include diagnosis and testing, but not treatment of infertility. • **Treatment of erectile dysfunction** (impotency) includes coverage of prescription drugs (such as Cialis) only, but not medical devices, medical treatment, or surgical services.	• For maternity coverage see the Maternity row in this schedule. • There is no cost-sharing for FDA-approved female contraceptives and female sterilization services. Benefits will be paid at 100% no deductible, from network providers. Certain contraceptives are payable under the row on Drugs (Medicines) coverage. • The Plan covers diagnosis of infertility (including testing), and these services do not accumulate to meet the annual maximum out-of-pocket limit. Medical, surgical and drug treatment of infertility is excluded. • No coverage for reversal of sterilization procedures. • No coverage for medical devices, medical treatment, or surgical treatment for erectile dysfunction. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions chapter.	**Fertility/ infertility testing:** After deductible met you pay 50% coinsurance. **Other services including FDA-approved contraceptives and sterilization**: No charge. Deductible does not apply.	**Fertility/ infertility testing:** You pay 50% coinsurance. **Other services including FDA-approved contraceptives and sterilization**: No charge.	**Fertility/ infertility testing:** Services are covered when using the EPO tier. **Other services including FDA-approved contra-ceptives and sterilization**: After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Genetic Testing and Counseling • The Plan covers **genetic testing** (when prior authorization is obtained) and genetic counseling for the following reasons only: a) in pregnant women diagnosed as high-risk. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are covered; b) state-mandated newborn screening tests for genetic disorders; c) BRCA testing as required by law; d) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics is covered if the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual. • **Genetic Counseling** is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive service in accordance with ACA regulations.	• **Genetic testing and genetic counseling services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • See the definitions of Genetic Counseling, Genetic Testing in the Definitions chapter. • No coverage for: a) pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. b) genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. c) genetic testing that is not listed as a covered benefit in the column to the left.	ACA mandated genetic tests & counseling: No charge. Deductible does not apply. Other genetic tests and counseling: After deductible met, no charge.	ACA mandated genetic tests & counseling: No charge. Other genetic tests and counseling: No charge.	Services are covered when using the EPO tier.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Hearing Services • Routine ear examination (audiology testing) is covered. • Implantable hearing aids are covered as a prosthetic device.	• Medically necessary implantable hearing devices (i.e. cochlear implants, osseointegrated implants including fully or partially implantable bone-anchored hearing aids (BAHAs)), for individuals with severe hearing loss (loss of 71 decibels or greater) are covered as a prosthetic device. • There will be no coverage for use of implantable hearing devices for conditions deemed experimental and investigational. • No coverage for external hearing aids, non-osseointegrated hearing devices, and examinations for placement/fitting of an external hearing aid or hearing aid supplies.	Hearing testing: After deductible met, you pay $10 copay/visit. See the Physician row, Hospital row and Corrective Appliances row for coverage for implantable hearing aids.	Hearing testing: You pay $10 copay/visit.	Hearing testing: After deductible met you pay 20% coinsurance.
Home Health Care and Home Infusion Therapy Services • The Plan covers services provided by a contracted home health agency. These services are provided in a member's home and are limited to **part-time or intermittent skilled nursing care** and, physical therapy, occupational therapy, speech-language therapy, medical social services, and other services as authorized by the PCP. The PCP is responsible for setting up a treatment plan describing the length, type, and frequency of the services to be provided.	• **Home health and home infusion therapy services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Supplied needed for use by the skilled home health or home infusion personnel are covered, but only during the course of their required services. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits. • Home services other than Skilled Nursing Care are not covered. Home health aides are not covered. See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document.	**Visit 1-30:** After deductible met, no charge. **Visits over 30:** After deductible met, you pay a $10 copay/visit.	**Visit 1-30:** No charge. **Visits over 30:** You pay a $10 copay/visit.	**All visits:** After deductible met you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Hospice • Hospice services (palliative care for terminally ill persons) include inpatient hospice care and outpatient home hospice care.	• Hospice care is available for covered individuals who have been diagnosed as terminally ill. To be considered terminally ill, the person must have a prognosis of six months or less to live. Hospice care includes palliative care provided in the home setting or in an inpatient hospice facility, and includes physician services, counseling, medications, other necessary services and supplies, and homemaker services covered only when ordered by a Physician. • Bereavement counseling beyond that included as part of the Hospice program is payable under the Behavioral Health benefits of this Plan. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • **Hospice services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	After deductible met, no charge.	No charge.	After deductible met you pay 20% coinsurance.
Hyperbaric Oxygen Therapy	• **Hyperbaric Oxygen Therapy services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	After deductible met, no charge.	No charge.	After deductible met you pay 20% coinsurance.
Infertility Services	• See the Family Planning row in this Schedule.			
Immunizations/Vaccinations	• See the Preventive Services row in this Schedule.			
Laboratory Services (Outpatient) • Includes technical and professional fees.	• Laboratory services are covered on an inpatient and outpatient basis when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some Laboratory services are covered at no charge under the Preventive services row in this Schedule. • **Allergy testing and Drug Testing services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	**Preventive lab services:** No charge. Deductible does not apply. **Non-preventive lab services:** After deductible met, no charge.	**Preventive lab services:** No charge. **Non-preventive lab services:** No charge.	**Preventive lab services:** Services are covered when using the EPO tier. **Non-preventive lab services:** After deductible met, you pay 20% coinsurance.

pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Genetic testing for routine pregnancy is not covered, unless mandated by law. • Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled in a timely manner. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). See Genetic Testing for additional information. See the Family Planning row and Drug row for information on contraceptive coverage. • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. • For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by a network provider acting within the scope of his/her license. Network providers are listed on the network directory described on the Contact Information Chart. • Elective induced abortion as noted to the right.	supplies need to operate the equipment and comprehensive lactation support and counseling). • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Prior Authorization. • **For information on Prior Authorization for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery**, call the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Elective induced abortion (termination of a pregnancy) is covered under these conditions: The induced abortion must be voluntary, an informed consent is obtained by the physician performing the procedure, and the physician's documentation must certify that the procedure is: a) The result of an act of rape or incest; or is b) Being performed for a woman suffering from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	**ACA mandated preventive services for pregnant females:** No charge. Deductible does not apply. **Other maternity services:** After deductible met, no charge. **Delivery expenses:** See the hospital and physician services rows.	**ACA mandated preventive services for pregnant females:** No charge. **Other maternity services:** No charge. **Delivery expenses:** See the hospital and physician services rows.	covered when using the EPO tier. **Other maternity services:** Services are covered when using the EPO tier. **Delivery expenses:** After deductible met, you pay 20% coinsurance. If the newborn's delivery is un-complicated and the infant is not required to stay in the Hospital longer than the mother, the inpatient Hospital deductible for non-network providers will be waived for the infant only.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Mental Health and Substance Abuse Treatment	• See the Behavioral Health row of this Schedule.			
Nondurable (Disposable) Medical Supplies • Coverage is provided for Medically Necessary nondurable disposable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual, including: a) Sterile surgical supplies used immediately after surgery. b) Colostomy and ostomy supplies. c) Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. d) Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. e) Dialysis supplies. f) Diabetic supplies (e.g., insulin syringes, test strips, lancets) are covered under the Prescription Drug Program. Insulin pump supplies are covered.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	After deductible met, no charge.	No charge.	After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Oral, Craniofacial, and TMJ Services • Accidental Injury to Teeth/Jaw • Plan covers dental examination and treatment of gingival tissue (gums) performed for the diagnosis or treatment of an oral or craniofacial tumor, cyst, abscess or acute injury. • Medically necessary Oral and/or Craniofacial Surgery is covered. Charges by an oral maxillofacial surgeon for reduction of a facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. • Treatment for Temporomandibular Joint (TMJ) dysfunction or syndrome as explained to the right.	• **Treatment of Accidental Injuries to the Teeth**: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: a) The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and b) The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and c) The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan for dental work. d) Approved dental treatment is payable without regard to whether there is also associated Dental Plan coverage. See also the definition of Injury to Teeth in the Definitions chapter of this document. • **The Plan covers the following oral, craniofacial, and TMJ treatment**: a) Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw, provided the services are medically necessary due to injury, the existence of cysts, tumors, or neoplasm, or functional disorder. A functional disorder is a medical condition that impairs the normal function of a body part or body process, such as a cleft palate that may impair the function of the palate (not including TMJ-see below for TMJ coverage). b) Medical Services (oral splints and physical therapy only-not surgery) to correct disorders of the temporomandibular jaw joint (also known as TMJ disorders). c) Surgical interventions related to the treatment of TMJ is only covered for cases of severe functional impairment, such as in cases of internal derangement and/or degenerative joint disease, in which the Plan has deemed services to be medically appropriate. Disease must be severe and disabling, refractory to non-surgical treatment, AND must be accompanied by at least one of the following: • Imaging evidence of disc displacement and/or perforation • Arthroscopic evidence of internal joint derangement • Tumor, cyst or fracture, dislocation or non-union d) Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury, and for reconstructive but not cosmetic purposes. • **Certain oral, craniofacial and TMJ services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • The following dental services are not covered: dental cleaning, dental x-rays, fillings, crowns, root canal, periodontal treatment, crowns, inlays, onlays, bridgework, dental appliances, orthodontia, surgical extraction of wisdom teeth, and cosmetic dental services. See the exclusions related to Dental Services in the Exclusions chapter.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Outpatient (Ambulatory) Surgery Facility/Center • Plan covers facility charges for procedures performed in an in-network accredited Ambulatory Surgical Center and associated services and supplies. • Ambulatory (Outpatient) Surgical Facility/Center is also sometimes referred to as a surgicenter, same day surgery, outpatient surgery center). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to an outpatient surgical facility/center requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Under certain circumstances, the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if this Plan determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. This medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a hospital or outpatient surgery facility.	**Kern Medical:** After deductible met, no charge. **Contracted Select network free-standing outpatient surgery facility:** After deductible met, you pay a $50 copay per outpatient admission **Contracted Select network hospital-based outpatient surgery center**: After deductible met, you pay a $150 copay per outpatient admission	**Kern Medical:** No charge. **Contracted EPO network free-standing outpatient surgery facility:** You pay a $50 copay per outpatient admission **Contracted EPO network hospital-based outpatient surgery center**: You pay a $150 copay per outpatient admission	**Kern Medical:** Coverd using the EPO tier. **Contracted Plus network free-standing outpatient surgery facility:** After deductible met, you pay 20% coinsurance. **Contracted Plus network hospital-based outpatient surgery center**: After deductible met, you pay 20% coinsurance.
Prescription Drugs (Outpatient)	• See the Drug row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Preventive Care Services The **preventive services payable by this Plan are designed to comply with ACA regulations** including the current A and B recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable preventive services (such as **CDC-recommended immunizations** and screening services for children and adults, screening mammogram, etc.): • https://www.healthcare.gov/what-are-my-preventive-care-benefits • https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, • http://www.cdc.gov/vaccines/schedules/hcp/index.html, and • http://www.hrsa.gov/womensguidelines/. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • Preventive services are payable without cost sharing when obtained from Network providers. If there is no Network provider who can provide the preventive service, the Plan will authorize coverage by an out-of-network provider without cost-sharing or dollar limit. • When performed in primary practices, **topical fluoride varnish** to the primary teeth of children is payable through age 5 years. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.	With respect to preventive services, the following applies to covered services: • In accordance with ACA, certain additional preventive care expenses are payable for all covered females as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, FDA-approved contraceptives, screening for gestational diabetes, genetic counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, and while breastfeeding coverage is provided for breastfeeding equipment and supplies needed to operate equipment and lactation support. • If a ACA preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use **reasonable medical management techniques** (such as age, frequency, location, method) to determine coverage parameters. • If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit. For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the cholesterol screening test. • The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive. • See the Drug row for information on payment for certain immunizations as well as over-the-counter (OTC) and prescription drugs in accordance with ACA requirements. • In addition to the ACA mandated preventive services, the Plan's will pay for: an annual preventive care adult medical examination, well child visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older, annual pap smear, fecal occult testing, a screening colonoscopy every 10 years starting age 50 to age 75, and annual screening mammogram for women age 40 and over unless needed sooner for women at high-risk. • In compliance with ACA, the Plan covers the following preventive services for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors: **intensive behavioral counseling** interventions to promote a healthful diet and physical activity for CVD prevention. For children age 6 years and older with obesity, Plan covers Physician-prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • No coverage for immunizations provided for travel-related or work-related purposes.	No charge. Deductible does not apply.	No charge.	Services are covered when using the EPO tier

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.			
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered at no charge under the Preventive services row in this Schedule. • Radiation therapy is payable. • **Certain services (including but not limited to angiogram, CT scan, MRI/MRA or PET scan, discogram, embolization) require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	**Radiology Imaging tests like CT, MRI, PET scan at Kern Medical:** After deductible met, you pay $25 copay/visit. **Radiology Imaging tests like CT, MRI, PET scan at another Select network facility:** After deductible met, you pay $50 copay/visit. **Other radiology services and radiation therapy:** After deductible met, no charge.	**Radiology Imaging tests like CT, MRI, PET scan at Kern Medical:** You pay $25 copay/visit. **Radiology Imaging tests like CT, MRI, PET scan at another EPO network facility:** You pay $25 copay/visit. **Other radiology services and radiation therapy:** No charge.	**Radiology Imaging tests like CT, MRI, PET scan at Kern Medical:** Covered when using the EPO Tier. **Radiology Imaging tests like CT, MRI, PET scan at another Plus network facility:** After deductible met, you pay 20% coinsurance. **Other radiology services and radiation therapy:** After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

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***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier

Reconstructive Services (and Breast Reconstruction After Mastectomy)
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are subject to the same cost-sharing that is applicable to other medical and surgical services and supplies provided under this Plan.
	• Reconstructive surgery is covered if its purpose is to **correct, repair, or improve function of an abnormal structure** of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. To be payable, the primary result of the procedure must not be a changed or improved physical appearance for cosmetic purposes only, but rather a procedure to improve function, to the extent possible.
	• Reconstructive surgery is covered under certain circumstances which include, but are not limited to:
	a) Correction, repair or improve function of an abnormal structure of the body caused by congenital birth defect, developmental abnormalities, trauma, infection, tumors, or disease, which cause significant anatomical functional impairment, but only if such surgery is reasonably expected to correct the condition.
	b) Breast reconstruction as explained in the column to the left.
	• Any other cosmetic, plastic, or related reconstructive surgeries are not covered, including procedures performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. The fact that a Member may have psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a covered reconstructive procedure.
	• **Certain reconstructive services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter.
		Physician services payable according to the Physician services row of this Schedule.
		
		Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
		
		Hospital services payable according to the Hospital row of this Schedule.
			Physician services payable according to the Physician services row of this Schedule.
			
			Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
			
			Hospital services payable according to the Hospital row of this Schedule.
				Physician services payable according to the Physician services row of this Schedule.
				
				Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
				
				Hospital services payable according to the Hospital row of this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Rehabilitation Services (including Physical, Occupational & Speech Therapy, Cardiac rehab, Pulmonary rehab, Neurocognitive rehab.) • Short term **active**, **progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active**, **progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Inpatient and outpatient Rehabiliation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Covered Rehabilitation therapy services include: a) Inpatient rehabilitation facility admission. b) **Short-term physical therapy (PT), occupational therapy (OT) and/or speech therapy (ST**) to treat acute conditions when significant/continuous functional improvement can be expected in a predictable time, beginning from the date of the initial evaluation for any separate and distinct illness or condition. c) Cardiac and pulmonary rehabilitation services and neurocognitive rehabilitation therapy. d) These rehabilitation therapy services noted above are **payable to a maximum of 60 visits per incident per year for all therapies combined. An incident is an injury or an illness.** • **Physical & Occupational Therapy:** Medically Necessary services are payable, as certified by a Physician, rendered by a certified or licensed physical therapist or registered occupational therapist. Therapy rendered by a licensed therapist to restore the loss or impairment of motor functions resulting from illness, disease or Injury. Coverage ends once maximum medical recovery has been achieved (as determined by the Plan) and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered. • **Speech Therapy:** is payable limited to restoration of speech that is lost due to an illness or injury, or correction of speech deficits related to an accident or surgical procedure. • **Cognitive/Neurocognitive Rehabilitation:** is payable when cognitive deficits have been acquired as a result of neurologic impairment due to moderate to severe traumatic brain injury, brain surgery, stroke, or encephalopathy and treatment is expected to make significant cognitive improvement. • Maintenance Rehabilitation, Habilitation services and Group PT (such as aquatic therapy or hydrotherapy), Group OT and Group Speech Therapy are not covered. The Plan covers direct patient contact, one on one, therapy modalities. See specific exclusions relating to Rehabilitation in the Exclusions chapter and the definition of Maintenance Rehabilitation and Habilitation in the Definitions chapter.	**Outpatient Rehab Therapy:** After deductible met, no charge. **Inpatient Rehab Admission:** After deductible met, you pay $100 copay/day up to $500/admission.	**Outpatient Rehab Therapy:** No charge. **Inpatient Rehab Admission:** You pay $100 copay/day up to $500/admission.	**Outpatient Rehab Therapy:** After deductible met, you pay 20% coinsurance. **Inpatient Rehab Admission:** After deductible met, you pay 20% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Routine Costs (associated with an approved clinical trial) • In accordance with law the Plan covers Routine Costs associated with an approved clinical trial.	• Routine costs means services and supplies incurred by an eligible individual during participation in an approved clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. See also the definition of Experimental.	For payment information, refer to the row of this Schedule that relates to the Routine Cost that is being provided. For example, for emergency room services, see the Emergency room row.		
Second and Third Physician Opinions • A second opinion consultation is covered. Members have the right to request a second opinion when: a) The PCP or the referred specialist gives a diagnosis or recommends a treatment plan a Member is not satisfied with; b) When the Member is not satisfied with the result of treatment received; c) When diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including a chronic condition; d) A PCP and the referred specialist are unable to diagnose a condition, or test results or treatment plans are conflicting.	• A second opinion is the process of a patient requesting an examination and evaluation of a health condition by a second physician to verify or challenge a diagnosis and treatment plan, or to offer an alternative diagnosis and/or treatment approach to what was originally given by the preliminary physician. • **Second opinions must be prior authorized.** To request an authorization for a second opinion, call Kern Legacy Health Plan, Health Plan Services at: 661- 868-3280 or 1-855-308-5547 (option 1, then 5). • The Plan will direct requests for a second opinion to providers who specializes in the illness, disease, or condition, within the network. In the event that an in-network provider is not available, the Plan may refer to a non-network provider. Network Plus members **may not** self-refer to a Plus benefit tier provider or an out-of-network provider for a second opinion to be considered payable by the Plan. Only second opinions authorized and directed by the Plan will be considered for coverage.	For payment information, refer to the Physician row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a skilled nursing facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to a Skilled nursing facility or Subacute facility (also called a Long Term Acute Care facility) requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Services must be ordered by a Physician. • To determine if a facility is a skilled nursing facility or subacute facility/long term acute care facility, see the Definitions chapter of this document. • Skilled Nursing Facility confinement or Subacute care facility confinement is **payable up to 100 days per calendar year**. Care in a semi-private room in a skilled nursing facility is covered. Hospitalization prior to admittance to a skilled nursing facility is not required. • 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.	After deductible met, no charge.	No charge.	After deductible met, you pay 20% coinsurance.
Sleep Study	• When ordered by a network physician, a diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) is covered when performed in a network healthcare facility. • **Sleep study services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Home sleep studies and sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not covered.	After deductible met, no charge.	No charge.	After deductible met, you pay 20% coinsurance.
Substance Abuse/Substance Use Treatment	• See the Behavioral Health row of this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.

See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue including bone marrow, autologous & peripheral stem cells, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, liver/kidney, lung(s), along with the facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. • Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. • When both the recipient and the donor are Members, each is entitled to the benefits of this Plan. • Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplantation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • All transplant-related services must be provided at/or arranged by a Transplant Facility designated and approved by the Plan. • No benefits will be provided for a pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the Member has received a kidney transplant. • For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. See also the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • **Transplant Related Travel Benefit:** When prior authorized, certain transplant related travel and lodging benefits are payable for necessary travel to a Plan-approved facility for pre-transplant work-up, transplant procedure and post-transplant treatment. a) Transplant Recipient and One Companion: Transportation limited to 6 trips/episode and $250/person roundtrip; Hotel limited to one room double occupancy up to $100/day for up to 21 days/trip; Other expenses such as parking, taxi limited to $25/day per person for up to 21 days/trip. b) Donor*: Transportation limited to one trip/episode and $250 roundtrip; Hotel limited to $100 per day for up to 7 days; Other expenses such as parking, taxi limited to $25/day per person for up to 7 days. *Benefits for the donor will be reduced by any benefits the donor receives from his or her own medical plan. Donor costs for a member are only covered when the recipient is also a County of Kern Medical Plan member.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.

SCHEDULE OF MEDICAL BENEFITS FOR THE KERN LEGACY SELECT AND NETWORK PLUS PLANS

This chart explains the benefits payable by the Kern Legacy Select and Kern Legacy Network Plus Plans.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	Kern Legacy Select (HDHP) Plan	Kern Legacy Network Plus Plan	
		Select Network	EPO Tier	Plus Tier
Vision Screening • Certain vision screening for children is payable as a preventive service in accordance with ACA. • Medically necessary treatment-related eye/vision illness or injury is covered.	• Routine eye refraction vision services to determine the need for eyeglasses or contact lenses, vision therapy (orthoptics) and eyeglasses and contact lenses are not covered under the medical plan (except one pair of eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye such as with a cataract extraction as explained in the Corrective Appliances row of this Schedule). • No coverage for surgical correction of refractive errors and refractive keratoplasty procedures including procedures such as but not limited to Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser-Assisted In-Situ Keratomileusis (LASIK) or implantable contact lenses (ICL).	See the preventive services row in this Schedule	See the preventive services row in this Schedule	See the preventive services row in this Schedule
Wellness Services	See the Preventive services row of this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Deductible • When an annual deductible applies, it is the amount of money you must pay each calendar year before the Plan begins to pay benefits. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. • Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. • Copayments do not accumulate to meet the deductible. • When the deductible applies, it applies to all covered services except where otherwise noted in this Schedule of Medical Benefits.		No deductible.	No deductible.	$200 per person $400 per family (and at least two family members must meet the per person deductible each year before the family deductible is met)

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year year) before your medical plan starts to pay 100% for covered essential health benefits received from Network providers. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit. • In accordance with law, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, **no one individual in the family will be required to accumulate more than the Plan's "per person in a family" annual out-of-pocket limit**.	**The Medical Plan Out-of-Pocket Limit does not include or accumulate:** a) Premiums and/or contributions for coverage, b) Expenses for medical services or supplies that are not covered by the Medical Plan, c) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers, d) Penalties for non-compliance with Utilization Management program (prior authorization) requirements, e) Expenses for the use of non-network providers, except covered emergency services performed in an Out-of-Network Emergency Room, f) Charges in excess of a maximum benefit under the Medical Plan, and g) Expenses that are not considered to be essential health benefits, such as infertility services. • There are two Out-of-Pocket Limits under the EPO Medical Plan and the POS Medical Plan: one for medical plan expenses that does not include outpatient drugs, and one for outpatient drugs that does not include other medical plan expenses. Together these medical and outpatient drug Out-of-Pocket Limits will not exceed the Out-of-Pocket Limits required by law.	The following out-of-pocket limit includes medical plan benefits only: $1,000 per person $1,000 per person in a family $3,000 per family	The following out-of-pocket limit includes medical plan benefits only: $1,000 per person $1,000 per person in a family $3,000 per family.	The following out-of-pocket limit includes medical plan benefits only: $2,000 per person $2,000 per person in a family $4,000 per family.
		The out-of-pocket limit for outpatient prescription drugs is: $5,600 per person $5,600 per person in a family $10,200 per family.	The out-of-pocket limit for outpatient prescription drugs is: $5,600 per person $5,600 per person in a family $10,200 per family.	

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. Be sure to properly enroll your newborn if you want coverage under the County's medical plan for that child.	• **Elective Hospitalization requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Private room is covered when Medically Necessary or if the facility does not provide semi-private rooms. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if this Plan determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. This medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a hospital or outpatient surgery facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • **Newborn care**: Medically Necessary expenses incurred by an eligible, enrolled newborn infant including services and supplies furnished by a Hospital and by a Physician to care for the newborn infant during initial Hospital confinement. Inpatient Physician care includes, but is not limited to, examinations and the circumcision of male infants. See the Eligibility provisions (in a separate document) for how to properly enroll Newborns so coverage can be considered. • 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 deductible for non-network providers will be waived for the infant only. • **For the EPO Medical Plan, Admission from an Emergency Room Visit**: If you visit the emergency room of a non-network hospital and require admission to that non-network hospital, the Plan will pay the claims for covered services related to the admission at the non-network level of benefits. When stable, if you need continued hospitalization, the Plan will facilitate your transfer to an in-network facility to complete the treatment. The emergency visit to the emergency room of a non-network hospital will be paid in accordance with law as discussed in the definition of Allowed charge in this document.	**Contracted EPO Network facility:** You pay $100 copay/day up to $500/calendar year. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** You pay $100 copay/day up to $500/admission.	**Contracted Anthem Network facility:** You pay $150 copay/day up to $750/calendar year. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** You pay $150 copay/day up to $750/calendar year.	**Non-network facility:** After deductible met, you pay 30% coinsurance. **Emergency Inpatient Admission Out-of-Network (if Plan-approved):** You pay $150 copay/day up to $750/calendar year.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center, patient's home, or other covered health care facility location. Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if Medically Necessary)
  • Anesthesia provided by Physicians & Certified Registered Nurse Anesthetists (CRNA)
  • Hospitalists, Pathologist, Radiologist
  • Podiatrist (DPM)
  • Physician Assistant; Nurse Practitioner; Certified Nurse Midwife
• Medically necessary injections and professional services to inject the medication are covered.
• See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from Network providers. See also the Emergency Services row for payment of providers in an emergency room.
• Eye examination and hearing examination is covered to determine the need for correction of vision and hearing.
	• **Certain Physician & Health Care Practitioner services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure. See also the definition of Physician, Health Care Practitioner in the Definitions chapter.
	• **Assistant Surgeon fees** will be reimbursed for Medically Necessary services to a maximum of 18.4% of the eligible expenses allowed for the primary surgeon.
	• **Primary Care Physician (PCP)** means a Physician or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology. All other Physicians are considered specialists under this Plan. Health Care Practitioners under contract to a network provider, such as a nurse practitioner, certified nurse midwife, physician's assistant or therapist are also payable providers.
	• In accordance with law, there is no requirement to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• **Routine Foot Care Benefit**: Routine foot care administered by a licensed medical professional including a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• The Plan does not cover: non-surgical treatment of toe/foot deformities, routine foot care for treatment of corns, calluses, clipping of toenails, flat feet, fallen arches, weak feet, chronic foot strain, and asymptomatic complaints related to the feet. This exclusion does not apply when related to treatment of the foot secondary to diabetes or a neurological or vascular insufficiency affecting the feet. See also the Corrective Appliances row.
	• Blepharoplasty (surgical modification of the eyelid) is covered if deemed medically necessary by the Plan, but is not covered for cosmetic reasons such as lower eyelid blepharoplasty to improve puffy eyelid "bags" and/or to reduce the wrinkling of skin. **Prior authorization is required**.
	• Chelation therapy (a process of binding a substance) is covered when medically necessary (such as for treatment of heavy metal poisoning). **Prior authorization is required**.
		PCP visit:
		You pay
		$10 copay/visit.
		
		Specialist visit:
		You pay
		$15 copay/visit.
		
		Preventive Care Visits with PCP or Specialist:
		No charge.
		
		All other in-network Provider services:
		No charge.
		
		Provider services related to out-of-network ER visit, or emergency hospital admission:
		No charge.
			PCP visit:
			$15 copay/visit.
			
			Specialist visit:
			$25 copay/visit.
			
			Preventive Care Visits with PCP or Specialist:
			No charge.
			
			Provider services during inpatient admission, outpatient surgery, or ER visit:
			No charge.
				PCP visit or Specialist visit:
				After deductible met, you pay 30% coinsurance.
				
				Preventive Care Visits for children up to 2 years:
				After deductible met, 30% coinsurance to a max of $200/year.
				
				Preventive care for ages 2 and older:
				Not covered.
				
				Provider services during inpatient admission or outpatient surgery:
				After deductible met, you pay 30% coinsurance.
				
				Provider services during ER visit:
				Covered same as in-network.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Allergy Services • Includes allergy testing, allergy immunotherapy (allergy shots) and allergy antigen solution.	• **Allergy testing and allergy injections/shots (immunotherapy) services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	Allergy Testing, Allergy Shots, and Allergy Antigen performed when an office visit is billed is payable like a Physician office visit. See the Physician and Other Health Care Practitioners Services row. If an office visit is not billed to the Plan then there is no cost to the member for the allergy testing or allergy shots/antigen. Allergy testing performed by a laboratory is payable in accordance with the Laboratory services row of this Schedule.	Allergy Testing, Allergy Shots, and Allergy Antigen: No charge.	Allergy Testing, Allergy Shots, and Allergy Antigen: After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Ambulance Services for Medical Emergency
• **Ground vehicle emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness/injury;
  • for Medically Necessary **non-emergency medical transportation** such as inter-health care facility transfer (e.g. transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a special test/procedure).
• **Air/sea emergency transportation** is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition.
	Expenses for ambulance services are covered only when those services are for an **Emergency,** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-health care facility transport. Medically Necessary ambulance services are covered when one or more of the following criteria are met.
	a) Transportation is by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured; and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water/sea, fixed wing, and rotary wing air transportation.
	b) **For ground ambulance, member is taken:**
	- From home, the scene of an accident or medical Emergency to a Hospital;
	- Between Hospitals, including when the Plan requires transfer from an Out-of-Network to a Network Hospital;
	- Between a Hospital and a Skilled Nursing Facility or other approved Facility.
	c) **For air or sea/water ambulance, member is taken:**
	- From the scene of an accident or medical Emergency to a Hospital;
	- Between Hospitals, including when the Plan requires transfer from an Out-of-Network to a Network Hospital;
	- Between a Hospital and an approved Facility.
	Air ambulance will not be covered if the Member is taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if the Member is taken to a Physician's office or home.
	Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if the member is not taken to a facility.
	Emergency ambulance services do not require prior authorization.
	• **Ambulance and non-emergency transportation services are not covered when**:
	a) Another type of transportation can be used without endangering the member's health.
	b) For convenience of the member or the convenience of the family or doctor
	c) For trips to a Doctor's office or clinic, a morgue or funeral home.
	• **Non-emergency medical transportation** refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. Non-Emergency ambulance or medical transportation services deemed Not Medically Necessary by the Plan are not covered.
	• **Non-emergency medical transportation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.
		Emergency Transport: No charge.
		Non-emergency medical transport: No charge.
			Emergency Transport: No charge.
			Non-emergency medical transport: No charge
				Emergency Transport: No charge. Deductible does not apply.
				Non-emergency medical transport: After deductible met, you pay 30% coinsurance.

Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Bariatric Surgical Services • Initial surgery and repeat surgery is covered as outlined to the right. • See also the definitinon of Morbid Obesity.	• **Initial Bariatric Surgical Procedure:** is covered if the member has been compliant with the Physician's required weight management program and the procedure has been prior authorized by the Plan. **Requirements:** a) Must be 18 years or older. b) Must meet the body mass index (BMI) criteria for morbid (extreme) obesity as established by the National Institute of Health. NOTE: BMI can be calculated using the National Heart, Lung and Blood Institute website: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm and https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_dis.htm. c) Documented failure of prior non-invasive attempts at weight loss. d) Evidence of member completing, a six (6) month physician supervised weight loss program. e) Clearance by a mental health professional to determine psychological suitability for bariatric surgery and rigorous postoperative regimen. f) Nutritional assessment and preoperative counseling for post-operative dietary management. • **Repeat Bariatric Surgical Procedure:** is covered under the following circumstances: a) There is a complication related to the initial bariatric surgery that requires modification of the original surgical site (i.e. stricture or obstruction). b) The member met criteria for the initial bariatric procedure and had not lost weight in the first two post-surgical years to lower the BMI at least 10 units (BMI is expressed in units of kg/m^2 not in pounds). c) A repeat clearance by a mental health professional will be required to determine psychological suitability for repeat bariatric surgery and rigorous postoperative regimen. • Bariatric Surgical Procedures are **limited to a lifetime maximum of two bariatric surgical procedures**. • **Bariatric surgery services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details. • Procedures to remove excess skin after weight loss, including panniculectomy, are not a covered benefit unless determined by the Plan to be medically necessary.	See the Hospital and Physician services rows in this Schedule.	See the Hospital and Physician services rows in this Schedule.	See the Hospital and Physician services rows in this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **Employee Assistance Program (EAP) Services:** This plan offers EAP visits at no cost to you for professional confidential counseling. The phone number for the EAP program is listed on the Contact Information Chart in the front of this document. In addition to the EAP services the following benefits are available: • **Inpatient acute hospital admission, or residential treatment program.** See the Definitions chapter for the meaning of the term residential treatment. • **Outpatient visits** including crisis intervention, counseling, medication management and necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services**: partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Definitions chapter for the meaning of the term partial day care and intensive outpatient program. • Screening for tobacco use. For those who use tobacco products, the Plan covers tobacco cessation support described to the right.	• For assistance locating behavioral health providers best qualified to treat your needs please contact the Plan Administrator for your Medical Plan (see the Contact Information Chart in the front of this document.) • **Elective inpatient admission to an acute hospital for mental health or substance abuse treatment, or admission to a residential treatment program requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Behavioral Health **residential treatment program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. **Prior authorization is required for admission and drug testing.** • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • The Behavioral Health benefits of this Plan may be used for smoking/tobacco cessation counseling. **Tobacco Cessation support**: The Plan covers, at no cost from Network providers, at least two tobacco cessation attempts per person per year. A cessation attempt includes coverage for four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling) (without Prior Authorization). FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) are covered at no cost from Network retail pharmacy locations for a 90-day treatment regimen when prescribed by Physician or Health Care Practitioner (without prior authorization). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • Court ordered mental health and/or substance use disorder treatment is covered to the extent the treatment is a covered benefit and is medically necessary. • See the specific exclusions related to Behavioral Health Services, in the Exclusions chapter. Applied Behavior Analysis (ABA) Therapy is not a covered benefit.	**EAP Visits and Tobacco Cessation Counseling:** No charge. **Outpatient visits:** You pay $10 copay/visit. **Other Outpatient Services:** You pay $10 copay/visit. **Inpatient Hospital at contracted EPO facility or Emergency admission out-of-network**: You pay $100 copay/day up to $500/calendar year. **Residential Treatment Program:** You pay $100 copay/day up to $500/calendar year.	**EAP Visits and Tobacco Cessation Counseling:** No charge. **Outpatient visits:** You pay $15 copay/visit. **Other Outpatient Services:** You pay $15 copay/visit. **Inpatient: Hospital at Kern Medical:** No charge. **Other POS network hospital:** You pay $150 copay/day up to $750/calendar year. **Residential Treatment Program:** You pay $150 copay/day up to $750/calendar year.	After deductible met, you pay 30% coinsurance

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Birthing Center	• See also the definition of Birthing Center in the Definitions chapter.	Birthing Center services payable according to the Hospital row of this Schedule.	Birthing Center services payable according to the Hospital row of this Schedule.	Birthing Center services payable according to the Hospital row of this Schedule.
Blood Transfusions • Blood transfusions including blood processing, the cost of blood, unreplaced blood and blood products and equipment for its administration.	• Expenses related to autologous blood donation (patient's own blood) are covered for elective surgery.	No charge.	No charge.	After deductible met, you pay 30% coinsurance.
Chemotherapy • A regimen comprised of a single agent or a combination of agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs. • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Chemotherapy Drug Requirements: d) Use that is included as an indication on the drug's label as approved by the FDA. e) Use of an FDA-approved drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major drug compendia, medical literature, and/or accepted standards of medical practice. f) Use of drugs to treat toxicities or side effects of the cancer treatment regimen when the drug is administered in relation to chemotherapy, including off-label uses supported by medical literature. • Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home (see Home Health care) or in a Physician's office, see Physician's and Other Health Care Practitioners (above) in this Schedule of Medical Benefits. • One wig is payable up to $3,000/person per lifetime, for hair loss following chemotherapy or radiation therapy.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.
Chiropractic Services	• **EPO Plan**: Includes initial evaluation and chiropractic manipulation to a **maximum of 20 visits/calendar year**. • **POS Plan**: Includes initial evaluation and chiropractic manipulation to a **maximum of 30 visits/calendar year**. • **For the EPO Plan**, you may self-refer to any chiropractor in the MCS chiropractic network. Note that if a MCS network chiropractor determines you need more than 5 visits, the chiropractor will seek authorization from MCS.	You pay $10 copay/visit.	Plan pays 100% up to $20 per visit. You pay amounts over $20 per visit.	After deductible met, you pay 30% coinsurance.
Contraceptives	• See Family Planning row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
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***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Corrective Appliance is the general term for: Internal/external prosthetic devices (devices to replace a missing body part) and Orthotics (devices to support a weakened body part, such as a back brace) and are covered when Medically Necessary as determined by the Plan through the prior authorization process.
• Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows:
  • rental (but only up to the allowed purchase price of the device).
  • purchase of standard model. Rental or purchase determined by the Plan Administrator or its designee.
  • repair, adjustment or servicing of the device when Medically Necessary.
  • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Colostomy, ostomy and/or urinary catheter supplies.
	• **Prosthetic and Orthotics services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.
	• **Internal prosthetics**: The following, when Medically Necessary and surgically implanted; are covered, including but not limited to:
	  • Electronic heart pacemakers, intraocular lenses, and joint replacements
	  • Breast implant related to reconstruction following a mastectomy.
	• **External prosthetics**: The following, when Medically Necessary, are covered:
	  • Artificial limbs or eyes including the initial purchase and replacements due to physical growth. Artificial limbs are limited to standard items and must be adequate to provide a reasonable level of functionality for normal daily activities.
	  • Breast prostheses following a mastectomy.
	• Prosthetic devices will be replaced when they are no longer functional due to normal wear or physical growth. However, the repair or replacement of a device that has been lost or misused is not covered.
	• One eye examination and one pair of eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye such as with a cataract extraction. Sunglasses are not covered.
	• **Orthotics**: The Plan covers medically necessary orthotic devices, such as a back or knee brace, or cervical collar.
	  a) **Non-Foot Orthotics,** such as a back brace or knee brace, are payable when medically necessary, including necessary supplies, repair and servicing. A custom-made orthotic device is payable where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off-the-shelf) orthotic device.
	  b) Foot orthotics are not covered, except for **Podiatric (foot) appliances** for prevention of complications of diabetic nerve conditions, (limited to one (1) pair per calendar year). Foot orthotics that are not incorporated into a cast, splint, brace or strapping of the foot are not covered. Also one pair of **diabetic shoes** is covered per calendar year.
	• For hearing exams and hearing aids, see the Hearing row in this Schedule.
	• See these other rows: Non-durable Supplies, Durable Medical Equipment.
	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.
		Eyeglasses or contact lenses after surgery to remove the lens of the eye: Plan pays 100% up to $150/frame or lenses.
		
		All other Corrective Appliances: No charge
			Eyeglasses or contact lenses after surgery to remove the lens of the eye: Plan pays 100% up to $150/frame or lenses.
			
			All other Corrective Appliances: No charge.
				Eyeglasses or contact lenses after surgery to remove the lens of the eye: After deductible met you pay 30% coinsurance.
				
				All other Corrective Appliances: After deductible met you pay 30% coinsurance.

Dental Services	• See the Oral services row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Diabetes Self-Management Education	• Training and education for self-management of diabetes is covered. • **For the POS Plan**, coverage is provided for up to 4 visits/lifetime with a licensed dietitian for diabetes self-management education. • For diabetes supplies see the Durable Medical Equipment row and the Drug row.	No charge.	You pay $25 copay/visit.	After deductible met you pay 30% coinsurance.
Dialysis • Plan covers dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic renal disease is covered. • Plan covers hemodialysis or peritoneal dialysis (and supplies administered). Plan covers hospital-based, outpatient dialysis centers or home dialysis and training in the operating of dialysis equipment, including supplies for and maintenance of dialysis equipment used in a Member's home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **Dialysis services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • When you have reached end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. **It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible. **Medicare and ESRD:** Once you are eligible for Medicare, you must apply for enrollment in Medicare. If the application for enrollment is accepted, Medicare coverage may begin. Medicare coverage begins at different times for different people depending on the circumstances. Medicare coverage usually starts the first day of the 3rd month after the month in which a course of regular dialysis begins. All, or a portion of, the 3-month waiting period may be waived if you participate in a self-dialysis training program, or if you have a kidney transplant within the 3-month waiting period. **When you are on dialysis and covered by both Medicare and this group health plan, for the first 30 months (referred to a 30-month coordination period), your group health plan is the primary payer of your dialysis and other covered medical services.** It is important to note that the 30-month coordination period always begins on the date you are first eligible to enroll in Medicare due to ESRD. If for example, you fail to submit a timely application for Medicare or chooses not to apply for Medicare, the 30-month coordination period will be calculated with a start date based on the month in which you could have been enrolled, had you made an application for Medicare. Medicare becomes the primary payer of benefits after the 30-month coordination period ends, as long as you retain Medicare eligibility based on ESRD. A Medicare beneficiary may have more than one 30-month coordination period. Medicare entitlement (meaning eligibility and coverage under Medicare) because of ESRD, will end if you have not received dialysis for 12 months or if 36 months have passed since you had a successful kidney transplant.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.	After deductible met you pay 30% coinsurance.
Dietitian/Nutrition Services	• Certain dietary counseling may be payable as a Preventive Care (wellness) service in accordance with ACA requirements. As a **preventive counseling benefit** in compliance with ACA, the Plan covers the following services: for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to **intensive behavioral counseling interventions** to promote a healthful diet and physical activity for CVD prevention.	Preventive Counseling Benefit: No charge.	Preventive Counseling Benefit: No charge.	No coverage

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Drugs (Outpatient Medicines)
• Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Coverage is provided for prenatal vitamins, drugs required to be covered due to ACA, FDA-approved female contraceptives, insulin & syringes, and diabetic blood glucose testing supplies such as lancets, teststrips, etc.
• Most over-the-counter (OTC) non-sedating antihistamines, like Claritin and proton pump inhibitors like Prilosec are covered when prescribed by a network provider.
• Contact the Prescription Benefit Manager (PBM) for the following:
  • The list of drugs on the **Preferred Drug formulary**.
  • Information on **drugs needing prior authorization** (pre-approval) by the clinical staff of the Prescription Benefit Manager (PBM), such as specialty drugs and off label drug use.
  • Information on which **drugs have a limit to the quantity** payable by this Plan, such as sleeping pills.
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug option, such as drugs to control migraines.
	The Prescription Drug Program: Benefits for prescription drugs are provided through the Plan's Prescription Benefit Manager (PBM) (See the Contact Information Chart in the front of this document.)
	• If the cost of the drug is less than the copay/coinsurance, you pay just the drug cost.
	• **Specialty drugs** are available on an outpatient basis when ordered through and managed by the Prescription Benefit Manager (PBM). Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique or chronic conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, cancer or hepatitis. These drugs **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity.
	• Covered outpatient prescription drugs do accumulate to meet the annual Out-of-Pocket Limit. Copayments for drugs do not accumulate to meet the POS Plan's Deductible(s)
	• **ACA mandated drugs** (such as FDA-approved female contraceptives, certain over the counter medications and tobacco cessation products) are covered at no charge. See page 21 for information on ACA mandated over the counter medications and prescription drugs.
	• Certain **CDC recommended preventive care immunizations/vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Prescription Benefit Manager for more information.
	• **The POS Plan**: Kern Medical Affiliated Network offers **free workplace desk delivery services and reduced copays for generic medications.**
	• The Plan covers drugs which are prescribed by a dentist for dental care.
	• Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will not be covered until and unless a clinical review and formulary placement has been made by the Prescription Benefit Manager (PBM).
	• The drug benefits under these medical plan are "creditable" with Medicare. Creditable means the value of the medical plan drug benefit is expected to pay out as much as the standard Medicare Part D prescription drug plan will allow.
	• No coverage for male contraceptives, over-the-counter (OTC) medications except the Plan covers drugs required by ACA, fertility drugs, growth hormones, compound drugs, and anabolic steroids. See also the exclusions related to Drugs (Medicines) in the Exclusions chapter and the definition of "Experimental and/or Investigational" in the Definitions chapter.
		No deductible applies to outpatient drugs.
		
		ACA mandated drugs:
		No charge.
		Diabetes supplies (30-day):
		Lancets: $5 copay
		Teststrips: $10 copay
		
		Network Retail Pharmacy for up to a 30-day supply including Specialty drugs:
		- **Generic:** $5 copay
		- **Preferred Brand:** $10 copay
		- **Non-preferred Brand:** $25 copay
		
		Mail Order (Home Delivery) up to a 90-day supply:
		- **Generic:** $10 copay
		- **Preferred Brand:** $20 copay
		- **Non-preferred Brand:** $50 copay
		
		For emergency drugs only, **out-of-network drugs** reimbursed no more than what the Plan would have paid if you used a network pharmacy.
			No deductible applies to outpatient drugs.
			
			ACA mandated drugs:
			No charge.
			
			Kern Medical Pharmacies for 30-day supply generic drugs:
			No charge.
			
			Network Pharmacy for 30-day supply, and specialty drugs:
			- **Generic:** $5 copay
			- **Preferred Brand:** $15 copay
			- **Non-preferred Brand:** $30 copay
			
			Mail Order Service for 90-day supply:
			- **Generic:** $10 copay
			- **Preferred Brand:** $30 copay
			- **Non-preferred Brand:** $60 copay	

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Durable Medical Equipment (DME)
• Coverage is provided for Medically Necessary DME including oxygen, along with the medically necessary equipment and supplies required for oxygen administration, diabetic blood glucose meter and other medically necessary diabetes durable medical equipment. Coverage is provided for:
  • rental (but only up to the allowed purchase price of the Durable Medical Equipment). Rental of DME items may not become the property of the Member and must be returned to the DME provider when no longer needed or upon termination of the Member's coverage, whichever occurs first. If the equipment is not returned by the Member or returned in poor condition, the Member may be responsible for the replacement or repair cost unless the purchase price has been paid by the Plan;
  • purchase of standard model equipment. Rental or purchase determined by the Plan Administrator or its designee;
  • repair, adjustment or servicing of Medically Necessary DME;
  • replacement of Medically Necessary Durable Medical Equipment is when medically necessary (e.g. if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense).
	• **Certain Durable Medical Equipment services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.
	• Durable Medical Equipment (and supplies necessary for the function of the durable medical equipment) is covered when medically necessary and prescribed by a Physician.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. For prosthetics and orthotic devices, see the Corrective Appliances row of this Schedule. For disposable medical supplies, see the Non-durable supplies row.
	• For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies necessary to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable as outlined to the left.
	• Diabetes insulin pump and diabetes glucose meter and supplies needed to operate these devices are covered. Disposable diabetes supplies like test strips, lancets, insulin pen, syringes, injection aids and devices for the visually impaired diabetic are payable under the outpatient Drug benefit.
	• The following equipment is not covered:
	  a) Items obtained without a physician order.
	  b) Items that are deemed personal comfort items (i.e. humidifiers and bath/shower seats).
	  c) Exercise equipment, sports equipment, equipment intended to enhance athletic ability and hygienic equipment.
	  d) More than one DME device designed to provide essentially the same functional assistance.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter.
		Breast pump and supplies necessary to operate pump: No charge.
		
		Other DME: No charge.
			Breast pump and supplies necessary to operate pump: No charge.
			
			Other DME: No charge.
				Breast Pump and supplies necessary to operate pump: After deductible met you pay 30% coinsurance
				
				Other DME: After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Education Services	• Patient education to help manage health risks and/or conditions.	No charge.	No charge.	After deductible met you pay 30% coinsurance.

Emergency Room Facility, Urgent Care Facility
• Coverage is provided for:
  • a **hospital emergency room (ER)** visit for "emergency services" (as that term is defined in this Plan).
  • **Urgent Care** facility visit.
  • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit.
• The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an emergency room or urgent care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.
• See also the Ambulance row of this schedule.
	• **Emergency room:** The visit copayment will be waived if subsequent immediate hospitalization is required. See the Hospital row if you are admitted because of your emergency room visit.
	• In accordance with law, there is **no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit**.
	• Although members do not need prior referral from a PCP in an emergency situation, **members must contact their PCP as soon as possible (preferably within 48 hours) after receiving emergency or urgent care services** to ensure coordination of future treatment needs. The PCP will evaluate the medical situation and make all necessary arrangements to assume responsibility for continuing care.
	Once discharged from the emergency room or urgent care facility, in order for benefits to be payable by the Plan, the Member must obtain follow-up services from a contracted network provider or the care will not be covered.
	• Examples of common conditions treated in an emergency room or urgent care facility:
	COMMON CONDITIONS TREATED IN AN EMERGENCY ROOM (ER)
	▪ chest pain or heart attack ▪ seizure or head injury ▪ other major trauma
	▪ difficulty breathing ▪ severe bleeding ▪ loss of consciousness
	▪ stroke ▪ poisoning/overdose ▪ sudden loss of vision or blurred vision
	COMMON CONDITIONS TREATED IN AN URGENT CARE FACILITY
	▪ minor burn or injury ▪ ear infection or sinus infection ▪ allergic reactions (non-life threatening)
	▪ sprain, strain, broken bone ▪ mild asthma or bladder infection ▪ fever or flu-like symptoms or migraine
	▪ cough, cold, sore throat ▪ animal bites ▪ rash or other skin irritations
	• The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.
		Emergency Room (ER) visit for emergency services (in-network or out-of-network): You pay a $75 copay/visit.
		Urgent Care Facility visit (in-network): You pay a $15 copay/visit
			Emergency Room (ER) visit for emergency services (in-network or out-of-network): You pay a $75 copay/visit.
			Urgent Care Facility visit: You pay a $15 copay/visit.
				Emergency Room (ER) visit for emergency services (in-network or out-of-network): After deductible met, you pay a $75 copay/visit.
				Urgent Care Facility visit: After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Endoscopy Facility (Outpatient)	• See the outpatient surgery row of this schedule. • Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs (bronchoscopy), intestines (colonoscopy), bladder (cystoscopy), stomach (gastroscopy), etc.	See the outpatient surgery row of this schedule.		
Family Planning, Contraceptives, Infertility, and Erectile Dysfunction Services • Coverage is provided for ACA mandated preventive service FDA-approved **female contraceptives** such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive drug coverage. • **Sterilization services** (e.g., vasectomy, tubal ligation, tubal implants such as Essure). • **Fertility/infertility** services include diagnosis and testing, but not treatment of infertility. • **Treatment of erectile dysfunction** (impotency) includes coverage of prescription drugs (such as Cialis) only, but not medical device, medical treatment, or surgical services.	• For maternity coverage, see the Maternity row in this schedule. • There is no cost-sharing for FDA-approved female contraceptives and female sterilization services. Benefits will be paid at 100% no deductible, from network providers. Certain contraceptives are payable under the row on Drugs (Medicines) coverage. • No coverage for reversal of sterilization procedures. • No coverage for medical devices, medical treatment, or surgical treatment for erectile dysfunction. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions chapter. • **The EPO Plan** covers diagnosis of infertility (including testing), and these services do not accumulate to meet the annual maximum out-of-pocket limit. Medical, surgical and drug treatment of infertility is excluded. • **For the POS Plan**, no coverage for infertility diagnosis, testing or treatment.	**Fertility/ infertility testing:** You pay 50% coinsurance. **Other services including FDA-approved contraceptives and sterilization**: No charge.	**Fertility/ infertility testing:** No covered. **Other services including FDA-approved contraceptives and sterilization**: No charge.	After deductible met you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Genetic Testing and Counseling • The Plan covers **genetic testing** (when prior authorization is obtained) and genetic counseling for the following reasons only: a) in pregnant women diagnosed as high-risk. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are covered; b) state-mandated newborn screening tests for genetic disorders; c) BRCA testing as required by law; d) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics is covered if the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual. • **Genetic Counseling** is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive service in accordance with ACA regulations.	• **Genetic testing and Genetic counseling services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • See the definitions of Genetic Counseling, Genetic Testing in the Definitions chapter. • No coverage for: a) pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. b) genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. c) genetic testing that is not listed as a covered benefit in the column to the left.	ACA mandated genetic tests & counseling: No charge. Other genetic tests and counseling: No charge.	ACA mandated genetic tests & counseling: No charge. Other genetic tests and counseling: No charge.	After deductible met you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Hearing Services • Routine ear examination (audiology testing) is covered. • Implantable hearing aids are covered as a prosthetic device.	• Medically necessary implantable hearing devices (i.e. cochlear implants, osseointegrated implants including fully or partially implantable bone-anchored hearing aids (BAHAs)), for individuals with severe hearing loss (loss of 71 decibels or greater) are covered as a prosthetic device. • There will be no coverage for use of implantable hearing devices for conditions deemed experimental and investigational. • No coverage for external hearing aids, non-osseointegrated hearing devices, and examinations for placement/fitting of an external hearing aid or hearing aid supplies.	Hearing testing: You pay $10 copay/visit. See the Physician row, Hospital row and Corrective Appliances row for coverage for implantable hearing aids.	Hearing testing: You pay $10 copay/visit.	Hearing testing: After deductible met you pay 30% coinsurance.
Home Health Care and Home Infusion Therapy Services • The Plan covers services provided by a contracted home health agency. These services are provided in a member's home and are limited to **part-time or intermittent skilled nursing care** and, physical therapy, occupational therapy, speech-language therapy, medical social services, and other services as authorized by the PCP. The PCP is responsible for setting up a treatment plan describing the length, type, and frequency of the services to be provided.	• **Home health and home infusion therapy services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Supplied needed for use by the skilled home health or home infusion personnel are covered, but only during the course of their required services. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits. • Home services other than Skilled Nursing Care are not covered. Home health aides are not covered. See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • **EPO Plan**: no annual maximum number of home health visits. • **POS Plan**: Home health payable to a maximum of 40 visits/ calendar year.	**Visit 1-30:** No charge. **Visits over 30:** You pay a $10 copay/visit.	No charge.	After deductible met you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
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***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Hospice • Hospice services (palliative care for terminally ill persons) include inpatient hospice care and outpatient home hospice care.	• Hospice care is available for covered individuals who have been diagnosed as terminally ill. To be considered terminally ill, the person must have a prognosis of six months or less to live. Hospice care includes palliative care provided in the home setting or in an inpatient hospice facility, and includes physician services, counseling, medications, other necessary services and supplies, and homemaker services covered only when ordered by a Physician. • Bereavement counseling beyond that included as part of the Hospice program is payable under the Behavioral Health benefits of this Plan. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • **Hospice services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.	No charge.	No charge.	After deductible met you pay 30% coinsurance.
Hyperbaric Oxygen Therapy	• **Hyperbaric Oxygen Therapy services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.	No charge.	No charge.	After deductible met you pay 30% coinsurance.
Infertility Services	• See the Family Planning row in this Schedule.			
Immunizations/Vaccinations	• See the Preventive Services row in this Schedule.			
Laboratory Services (Outpatient) • Includes technical and professional fees.	• Laboratory services are covered on an inpatient and outpatient basis when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some Laboratory services are covered at no charge under the Preventive services row in this Schedule. • **Allergy testing and Drug Testing services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Prior Authorization chapter for more details.	**Preventive lab services:** No charge. **Non-preventive lab services:** No charge.	**Preventive lab services:** No charge. **Non-preventive lab services:** No charge.	**Preventive lab services:** After deductible met you pay 30% coinsurance **Non-preventive lab services:** After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Maternity Services • Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, complications of pregnancy, delivery, and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Genetic testing for routine pregnancy is not covered, unless mandated by law. • Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled in a timely manner. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). See Genetic Testing for additional information. See the Family Planning row and Drug row for information on contraceptive coverage. • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. • For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by a network provider acting within the scope of his/her license. Network providers are listed on the network directory described on the Contact Information Chart. • Elective induced abortion, as noted to the right.	• **ACA mandated preventive services for pregnant females**: certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, blood pressure screening throughout a pregnancy to check for preeclampsia, and when breastfeeding there is coverage for breastfeeding equipment and supplies need to operate the equipment and comprehensive lactation support and counseling). • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Prior Authorization. • **For information on Prior Authorization for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery, call** the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Elective induced abortion (termination of a pregnancy) is covered under these conditions: The induced abortion must be voluntary, an informed consent is obtained by the physician performing the procedure, and the physician's documentation must certify that the procedure is: a) The result of an act of rape or incest; or is b) Being performed for a woman suffering from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	**ACA mandated preventive services for pregnant females:** No charge. **Other maternity Services:** No charge. **Delivery expenses:** see the hospital and physician services rows.	**ACA mandated preventive services for pregnant females:** No charge. **Other maternity services:** No charge. **Delivery expenses:** see the hospital and physician services rows.	After deductible met you pay 30% coinsurance. If the newborn's delivery is un-complicated and the infant is not required to stay in the Hospital longer than the mother, the inpatient Hospital deductible for non-network providers will be waived for the infant only.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Mental Health and Substance Abuse Treatment	• See the Behavioral Health row of this Schedule.			
Nondurable (Disposable) Medical Supplies • Coverage is provided for Medically Necessary nondurable disposable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual, including: a) Sterile surgical supplies used immediately after surgery. b) Colostomy and ostomy supplies. c) Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. d) Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. e) Dialysis supplies. f) Diabetic supplies (e.g., insulin syringes, test strips, lancets) are covered under the Prescription Drug Program. Insulin pump supplies are covered.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	No charge.	No charge.	After deductible met you pay 30% coinsurance.

treatment of an oral or craniofacial tumor, cyst, abscess or acute injury. • Medically necessary Oral and/or Craniofacial Surgery is covered. Charges by an oral maxillofacial surgeon for reduction of a facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. • Treatment for Temporomandibular Joint (TMJ) dysfunction or syndrome as explained to the right.	c) The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan for dental work. d) Approved dental treatment is payable without regard to whether there is also associated Dental Plan coverage. See also the definition of Injury to Teeth in the Definitions chapter of this document. • **The Plan covers the following oral, craniofacial, and TMJ treatment**: a) Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw, provided the services are medically necessary due to injury, the existence of cysts, tumors, or neoplasm, or functional disorder. A functional disorder is a medical condition that impairs the normal function of a body part or body process, such as a cleft palate that may impair the function of the palate (not including TMJ-see below for TMJ coverage). b) Medical Services (oral splints and physical therapy only-not surgery) to correct disorders of the temporomandibular jaw joint (also known as TMJ disorders). c) Surgical interventions related to the treatment of TMJ is only covered for cases of severe functional impairment, such as in cases of internal derangement and/or degenerative joint disease, in which the Plan has deemed services to be medically appropriate. Disease must be severe and disabling, refractory to non-surgical treatment, <u>AND</u> must be accompanied by at least one of the following: • Imaging evidence of disc displacement and/or perforation • Arthroscopic evidence of internal joint derangement • Tumor, cyst or fracture, dislocation or non-union d) Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury, and for reconstructive but not cosmetic purposes. • **<u>Certain oral, craniofacial and TMJ services require Prior Authorization</u>** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • The following dental services are not covered: dental cleaning, dental x-rays, fillings, crowns, root canal, periodontal treatment, crowns, inlays, onlays, bridgework, dental appliances, orthodontia, surgical extraction of wisdom teeth, and cosmetic dental services. See the exclusions related to Dental Services in the Exclusions chapter.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.	Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row of this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Outpatient (Ambulatory) Surgery Facility/Center • Plan covers facility charges for procedures performed in an in-network accredited Ambulatory Surgical Center and associated services and supplies. • Ambulatory (Outpatient) Surgical Facility/Center is also sometimes referred to as a surgicenter, same day surgery, outpatient surgery center). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to an outpatient surgical facility/center requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if this Plan determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. This medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a hospital or outpatient surgery facility.	**Contracted network hospital outpatient surgicenter:** You pay a $150 copay per outpatient admission. **Free-standing outpatient surgery facility/center:** You pay a $50 copay per outpatient admission.	**Kern Medical:** No charge. **Contracted network free-standing outpatient surgery facility:** You pay a $100 copay per outpatient admission **Contracted network hospital-based outpatient surgery center**: You pay a $100 copay per outpatient admission	**Free-standing outpatient surgery facility:** After deductible met you pay 30% coinsurance. **Hospital-based outpatient surgery center**: After deductible met you pay 30% coinsurance.
Prescription Drugs (Outpatient)	• See the Drug row in this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Preventive Care Services The **preventive services payable by this Plan are designed to comply with ACA regulations** including the current A and B recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable preventive services (such as **CDC-recommended immunizations** and screening services for children and adults, screening mammogram, etc.): • https://www.healthcare.gov/what-are-my-preventive-care-benefits • https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, • http://www.cdc.gov/vaccines/schedules/hcp/index.html, and • http://www.hrsa.gov/womensguidelines/. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • Preventive services are payable without cost sharing when obtained from Network providers. If there is no Network provider who can provide the preventive service, the Plan will authorize coverage by an out-of-network provider without cost-sharing or dollar limit. • When performed in primary practices, **topical fluoride varnish** to the primary teeth of children is payable through age 5 years. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.	With respect to preventive services, the following applies to covered services: • In accordance with ACA, certain additional preventive care expenses are payable for all covered females as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, FDA-approved contraceptives, screening for gestational diabetes, genetic counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, and while breastfeeding coverage is provided for breastfeeding equipment and supplies needed to operate equipment and lactation support. • If a ACA preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use **reasonable medical management techniques** (such as age, frequency, location, method) to determine coverage parameters. • If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit. For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the cholesterol screening test. • The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive. • See the Drug row for information on payment for certain immunizations as well as over-the-counter (OTC) and prescription drugs in accordance with ACA requirements. • In addition to the ACA mandated preventive services, the Plan's will pay for: an annual preventive care adult medical examination, well child visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older, annual pap smear, fecal occult testing, a screening colonoscopy every 10 years starting age 50 to age 75, and annual screening mammogram for women age 40 and over unless needed sooner for women at high-risk. • In compliance with ACA, the Plan covers the following preventive services for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors: **intensive behavioral counseling** interventions to promote a healthful diet and physical activity for CVD prevention. For children age 6 years and older with obesity, Plan covers Physician-prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • No coverage for immunizations provided for travel-related or work-related purposes.	No charge.	No charge.	**Preventive Care Visits for children up to 2 years:** After deductible met, 30% coinsurance to a max of $200/year. **Preventive care for ages 2 and older:** Not covered.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.			
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered at no charge under the Preventive services row in this Schedule. • Radiation therapy is payable. • **Certain services (including but not limited to angiogram, CT scan, MRI/MRA or PET scan, discogram, embolization) services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.	No charge.	No charge.	After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network

Reconstructive Services (and Breast Reconstruction After Mastectomy)
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are subject to the same cost-sharing that is applicable to other medical and surgical services and supplies provided under this Plan.
	• Reconstructive surgery is covered if its purpose is to **correct, repair, or improve function of an abnormal structure** of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. To be payable, the primary result of the procedure must not be a changed or improved physical appearance for cosmetic purposes only, but rather a procedure to improve function, to the extent possible.
	• Reconstructive surgery is covered under certain circumstances which include, but are not limited to:
	  a) Correction, repair or improve function of an abnormal structure of the body caused by congenital birth defect, developmental abnormalities, trauma, infection, tumors, or disease, which cause significant anatomical functional impairment, but only if such surgery is reasonably expected to correct the condition.
	  b) Breast reconstruction as explained in the column to the left.
	• Any other cosmetic, plastic, or related reconstructive surgeries are not covered, including procedures performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. The fact that a Member may have psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a covered reconstructive procedure.
	• **Certain reconstructive services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter.
		Physician services payable according to the Physician services row of this Schedule.
		
		Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
		
		Hospital services payable according to the Hospital row of this Schedule.
			Physician services payable according to the Physician services row of this Schedule.
			
			Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
			
			Hospital services payable according to the Hospital row of this Schedule.
				Physician services payable according to the Physician services row of this Schedule.
				
				Outpatient surgery is payable according to the Outpatient (Ambulatory) Surgery row of this Schedule.
				
				Hospital services payable according to the Hospital row of this Schedule.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Rehabilitation Services (including Physical, Occupational & Speech Therapy, Cardiac rehab, Pulmonary rehab, Neurocognitive rehab.) • Short term **active**, **progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active**, **progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Inpatient and outpatient Rehabilitation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Covered Rehabilitation therapy services include: a) Inpatient rehabilitation facility admission. b) **Short-term physical therapy (PT), occupational therapy (OT) and/or speech therapy (ST)** to treat acute conditions when significant/continuous functional improvement can be expected in a predictable time, beginning from the date of the initial evaluation for any separate and distinct illness or condition. c) Cardiac and pulmonary rehabilitation services and neurocognitive rehabilitation therapy. d) These rehabilitation therapy services noted above are **payable to a maximum of 60 visits per incident per year for all therapies combined. An incident is an injury or an illness.** • **Physical & Occupational Therapy:** Medically Necessary services are payable, as certified by a Physician, rendered by a certified or licensed physical therapist or registered occupational therapist. Therapy rendered by a licensed therapist to restore the loss or impairment of motor functions resulting from illness, disease or Injury. Coverage ends once maximum medical recovery has been achieved (as determined by the Plan) and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered. • **Speech Therapy:** is payable limited to restoration of speech that is lost due to an illness or injury, or correction of speech deficits related to an accident or surgical procedure. • **Cognitive/Neurocognitive Rehabilitation:** is payable when cognitive deficits have been acquired as a result of neurologic impairment due to moderate to severe traumatic brain injury, brain surgery, stroke, or encephalopathy and treatment is expected to make significant cognitive improvement. • Maintenance Rehabilitation, Habilitation services and Group PT (such as aquatic therapy or hydrotherapy), Group OT and Group Speech are not covered. The Plan covers direct patient contact, one on one, therapy modalities. See specific exclusions relating to Rehabilitation in the Exclusions chapter and the definition of Maintenance Rehabilitation and Habilitation in the Definitions chapter.	**Outpatient Rehab Therapy:** No charge. **Inpatient Rehab Admission:** You pay $100 copay/day up to $500/calendar year.	**Outpatient Rehab Therapy:** No charge. **Inpatient Rehab Admission:** You pay $150 copay/day up to $750/calendar year.	**Outpatient Rehab Therapy:** After deductible met, you pay 30% coinsurance. **Inpatient Rehab Admission:** After deductible met, you pay 30% coinsurance.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Routine Costs (associated with an approved clinical trial) • In accordance with law the Plan covers Routine Costs associated with an approved clinical trial.	• Routine costs means services and supplies incurred by an eligible individual during participation in an approved clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. See also the definition of Experimental.	For payment information, refer to the row of this Schedule that relates to the Routine Cost that is being provided. For example, for emergency room services, see the Emergency room row.		
Second and Third Physician Opinions • A second opinion consultation is covered. Members have the right to request a second opinion when: a) The PCP or the referred specialist gives a diagnosis or recommends a treatment plan a Member is not satisfied with; b) When the Member is not satisfied with the result of treatment received; c) When diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including a chronic condition; d) A PCP and the referred specialist are unable to diagnose a condition, or test results or treatment plans are conflicting.	• A second opinion is the process of a patient requesting an examination and evaluation of a health condition by a second physician to verify or challenge a diagnosis and treatment plan, or to offer an alternative diagnosis and/or treatment approach to what was originally given by the preliminary physician. • **For the EPO Plan, Second opinions must be prior authorized**. To request an authorization for a second opinion, call the EPO Plan Administrator. No prior authorization of a second opinion is required under the POS plan. • The Plan will direct requests for a second opinion to providers who specializes in the illness, disease, or condition, within the network. In the event that an in-network provider is not available, the Plan may refer to a non-network provider. Only second opinions authorized and directed by the Plan will be considered for coverage.	For payment information, refer to the Physician row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a skilled nursing facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to a Skilled nursing facility or Subacute facility (also called a Long Term Acute Care facility) requires Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Services must be ordered by a Physician. • To determine if a facility is a skilled nursing facility or subacute facility/long term acute care facility, see the Definitions chapter of this document. • **For the EPO Plan**, Skilled Nursing Facility confinement or Subacute care facility confinement is **payable up to 100 days per calendar year**. Care in a semi-private room in a skilled nursing facility is covered. Hospitalization prior to admittance to a skilled nursing facility is not required. • **For the POS Plan**, Skilled Nursing Facility confinement or Subacute care facility confinement is **payable up to 120 days per calendar year**. Care in a semi-private room in a skilled nursing facility is covered. Hospitalization prior to admittance to a skilled nursing facility is not required. • 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.	No charge.	No charge.	After deductible met you pay 30% coinsurance.
Sleep Study	• When ordered by a network physician, a diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) is covered when performed in a network healthcare facility. • **Sleep study services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • Home sleep studies and sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not covered.	No charge.	No charge.	After deductible met you pay 30% coinsurance.
Substance Abuse/Substance Use Treatment	• See the Behavioral Health row of this Schedule.			

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.

See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.

***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue including bone marrow, autologous & peripheral stem cells, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, liver/kidney, lung(s), along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. • When both the recipient and the donor are Members, each is entitled to the benefits of this Plan. • Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplantation services require Prior Authorization** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See also the Prior Authorization chapter for more details. • All transplant-related services must be provided at/or arranged by a Transplant Facility designated and approved by the Plan. • No benefits will be provided for a pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the Member has received a kidney transplant. • For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. See also the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • **Transplant Related Travel Benefit:** When prior authorized, certain transplant related travel and lodging benefits are payable for necessary travel to a Plan-approved facility for pre-transplant work-up, transplant procedure and post-transplant treatment. a) Transplant Recipient and One Companion: Transportation limited to 6 trips/episode and $250/person roundtrip; Hotel limited to one room double occupancy up to $100/day for up to 21 days/trip; Other expenses such as parking, taxi limited to $25/day per person for up to 21 days/trip. b) Donor*: Transportation limited to one trip/episode and $250 roundtrip; Hotel limited to $100 per day for up to 7 days; Other expenses such as parking, taxi limited to $25/day per person for up to 7 days. *Benefits for the donor will be reduced by any benefits the donor receives from his or her own medical plan. Donor costs for a member are only covered when the recipient is also a County of Kern Medical Plan member.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.	Physician services, Hospital admission, Drugs, Lab and Radiology services payable according to the Physician services, Hospital Inpatient, Drugs, Laboratory and Radiology rows of this Schedule. Transplant related travel benefits reimbursed to the maximums noted to the left.

SCHEDULE OF MEDICAL BENEFITS FOR THE EPO AND POS PLANS

This chart explains the benefits payable by the EPO Plan and the POS Plan.
See also the Exclusions and Definitions chapters of this document for important information. When a deductible applies, all benefits are subject to the deductible except where noted.
***IMPORTANT: Out-of-Network providers are not payable except for emergency services in an emergency room.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	EPO Medical Plan	POS Medical Plan	
		EPO Network	In-network	Non-network
Vision Screening • Certain vision screening for children is payable as a preventive service in accordance with ACA. • Medically necessary treatment-related eye/vision illness or injury is covered.	• Routine eye refraction vision services to determine the need for eyeglasses or contact lenses, vision therapy (orthoptics) and eyeglasses and contact lenses are not covered under the medical plan (except one pair of eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye such as with a cataract extraction as explained in the Corrective Appliances row of this Schedule). • No coverage for surgical correction of refractive errors and refractive keratoplasty procedures including procedures such as but not limited to Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser-Assisted In-Situ Keratomileusis (LASIK) or implantable contact lenses (ICL).	See the preventive services row in this Schedule	See the preventive services row in this Schedule	See the preventive services row in this Schedule
Wellness Services	See the Preventive services row of this Schedule.			

MEDICAL NETWORKS AND PCP REFERRALS

NETWORK SERVICES: Network Health Care Providers have agreements with the County or the County's contracted Preferred Provider network under which they provide health care services and supplies for a favorable negotiated discount fee for plan participants. When a plan participant uses the services of a network Health Care Provider, the Plan participant is responsible for paying their applicable cost-sharing (deductibles, copayment and coinsurance) on the discounted fees, for any Medically Necessary covered services or supplies, subject to the Plan's limitations and exclusions.

Your lowest out-of-pocket costs occur when you use a network provider.

There are different networks according to the medical plan in which you are enrolled, as outlined in the chart below:

Name of County-Sponsored Medical Plan:	The Network is:
Kern Legacy Select (HDHP) Plan	Kern Health Care Network - Select Network
Kern Legacy Network Plus Plan	EPO Tier uses: Kern Health Care Network - EPO Network Plus Tier uses: Kern Health Care Network - Plus Network
Exclusive Provider Organization (EPO) Plan	County of Kern EPO Network
Point of Service (POS) Plan	Anthem Blue Cross Network

Because Health Care Providers are added to and deleted from networks periodically throughout the year it is best if you ask the Plan Administrator IF the provider is still participating with your medical plan network, or contact the network each time BEFORE you seek services to assure you will be able to receive their discounted price for the services you need.

Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send their bills.

The Network Health Care Provider generally deals with the Plan directly for any additional amount due. Note that with respect to claims involving any third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the contract between the Health Care Providers and the Network may not require them to adhere to the discounted amount the Plan pays for covered services, and the providers may charge their usual non-discounted fees.

IMPORTANT NOTE
Because providers are added to and dropped from a network periodically throughout the year it is best if you ask the Plan Administrator IF the provider is still participating with your medical plan network, or contact the network each time BEFORE you seek services.
For a list of Network providers, at no cost, see
the Contact Information Chart in the front of this document.

You may also verify if your Health Care Provider is a network provider by contacting the appropriate Network at their phone number and website listed on your ID card and also on the Contact Information Chart in the front of this document.

OUT-OF-NETWORK SERVICES: Certain medical plans listed in this document include coverage for out-of-network services (refer to the Schedule of Medical Benefits).

Out-of-Network Health Care Providers (also called Non-Network, and Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. Upon submission of an itemized bill for covered services, the Plan will reimburse the Plan participant for the Allowed Charge (as defined in this document) for any Medically Necessary covered services or supplies, subject to the Plan's deductibles, coinsurance (on non-discounted services), copayments limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made for an eligible medical service.

- **CAUTION: Out-of-Network Health Care Providers may bill you (the member or Plan participant) for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing.** Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using Network providers.** (See the definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.
- It generally costs you more money out of your own pocket if you use out-of-network providers, except emergency services provided in an emergency room.

NO AUTHORIZATION REQUIRED

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain care from a health care professional in the medical plan network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the your medical plan network.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

Three of the medical plans are considered to be EPO plans: the Kern Legacy Select Plan, the Kern Legacy Network Plus Plan and the EPO Medical Plan. The Exclusive Provider Organization (EPO) is a network of Hospitals, Physicians, medical laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide medically necessary covered services and supplies for favorable negotiated discount fees applicable only to EPO Plan participants.

- **Under the EPO Plan there is generally coverage ONLY when you use an EPO provider**.
- The only exception is if you are have an emergency. In that case you should use the nearest emergency room and later, send your claims to your medical plan Claims Administrator who will pay the emergency services according to how EPO provider claims are paid.

When you are enrolled in a Medical Plan that is an EPO plan, you and each of your covered Dependents must choose a Primary Care Physician (PCP) at the time of enrollment. Your PCP will provide for all your health care needs either by providing medically necessary covered services or supplies or by referring you to specialists or other Health Care Providers who usually are members of the EPO. You or any of your covered Dependents may change your PCP at any time. For information regarding how to choose or change your PCP, contact the Plan Administrator for your Medical Plan (listed on the Contact Information Chart in the front of this document.) If you receive medically necessary covered services or supplies from an EPO Provider, you will pay the least amount of money for those services or supplies.

POINT OF SERVICE OPTION (POS)

A point-of-service plan (POS) is a type of managed care plan that is partly like an EPO plan and partly like a Preferred Provider Organization (PPO) plan. In the POS Plan members can decide whether to use the services of an in-network provider or use a non-network provider. In other words, participants may go outside of the provider Network for health care services. This means that a POS Plan Participant may seek treatment from **any** licensed provider (but the Plan's reimbursement for non-network provider will be less than if a network provider is used).

Members in the POS plan do not need to select a Primary Care Physician (PCP) and there is no requirement to obtain prior authorization or a referral to visit a non-network provider. However, choosing a provider who is not affiliated with the Network will reduce the benefits provided by the Plan. This means that when you go outside of the Network, you'll have to pay more of the cost of covered services.

In the POS plan, at the time you need medically necessary covered services or supplies, you may obtain them:

1. By self-referring to a Network Physician or Health Care Provider; or
2. From any Physician or Health Care Provider of your choice who is not a member of the Network (Out-of-Network Provider).

Your Out-of-Pocket expenses will be smaller if you choose a Network provider, while your greatest Out-of-Pocket expenses occur if you choose an Out-of-Network Provider.

SERVICE AREA

A **"Service Area"** is a geographic area serviced by the Network Health Care Providers who have agreements with the Plan's network(s). Before you obtain services or supplies from an Out-of-Network Health Care Provider, you can find out whether the Plan will provide Network or Out-of-Network benefits for those services or supplies by contacting the network or the Medical Plan Claims Administrator at their phone number and website shown on the Contact Information Chart in the front of this document.

DIRECTORIES OF NETWORK PROVIDERS

A directory of Network health care providers is available (at no cost) on the Medical Network's website (listed on the Contact Information Chart in the front of this document).

Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by contacting the network at their telephone number or website (to access their free provider network directory) shown on the Contact Information Chart in the front of this document.

Remember, because providers are added to and dropped from a network periodically throughout the year it is best if you ask the Plan Administrator IF the provider is still participating with your medical plan network, or contact the network each time BEFORE you seek services.

CARE MANAGEMENT (OVERVIEW OF PCP SELECTION AND REFERRAL PROCESS)

PCP Care Management: All Members in the Kern Legacy Select Plan, the Kern Legacy Network Plus Plan and the EPO Medical Plan must select a Primary Care Physician (PCP). The PCP can provide preventive and routine medical care, coordinate non-emergency hospital care and can refer Members to a network Specialist when necessary. The PCP plays an essential role in the overall coordination of health care.

A PCP can be a network Physician from any of the following specialties: Family Practice, General Practice, Internal Medicine, OB/GYN, and/or Pediatrics. All other physicians are considered to be specialists. In accordance with law, there is no requirement to obtain a referral or prior authorization before visiting an OB/GYN provider for any covered services. For children, you may designate a pediatrician (including pediatric subspecialties) as the primary care provider, if provider is accepting patients.

To select a PCP or change a PCP, contact the Plan Administratitor for your Medical Plan (listed on the Contact Information chrat in the front of this document).

If a Member requires specialty care that the PCP cannot provide, the PCP will refer the Member to a Network physician or other appropriate Network medical professional. Under certain circumstances, if a Member is receiving treatment from a Specialist and requires care from a different Specialist, a Specialist to Specialist referral is permitted.

Typically, the PCP will refer Members to contracted Network providers; however, the Member is ultimately responsible for ensuring their health care providers are in-network. If the County's medical plan is a secondary payor (due to Coordination of Benefits with another plan), a referral will not be required.

Failure to obtain a referral for services that require referral from the PCP will result in a denial of coverage.

MEDICAL PLAN OPTION	REFERRAL PROCESS
Kern Legacy Select Medical Plan **Kern Legacy Network Plus Medical Plan**	Members are **not required** to obtain a PCP referral to visit a network OB/GYN, Chiropractor, or an Outpatient Mental Health/Substance Use Disorder provider. Consultations with all other types of Specialists **will require a referral** from the member's PCP.
EPO Medical Plan	Members are **not required** to obtain a PCP referral to visit a network OB/GYN. Consultations with all other types of Specialists **will require a referral** from the member's PCP.
POS Medical Plan	Members are **not required** to select a PCP or obtain a referral before seeing any network or non-network provider.

PRIOR AUTHORIZATION AND THE UTILIZATION MANAGEMENT (UM) PROGRAM

Purpose of the Utilization Management (UM) Program: Your plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the County to afford the cost of maintaining your plan.

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the County is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

Management of the Utilization Management Program: The Plan's Utilization Management Program is administered by various independent professional Utilization Management Companies operating under a contract with the County (hereafter referred to as the UM Company). Certain outpatient drugs may require Prior Authorization as managed by the Prescription Drug Program. The contact information for the UM Companies and Prescription Drug Program appear in the Contact Information Chart in the front of this document.

The health care professionals in the various UM Companies focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical, surgical and prescription drug services. In carrying out its responsibilities under the Plan, the appropriate UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Medical management (prior authorization) requirements described in this chapter do not apply when coverage under this Plan is secondary to another plan providing primary benefits for a covered individual.

Elements of the Utilization Management Program: The Plan's Utilization Management Program consists of:

1. **Prior Authorization (preservice) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;
3. **Retrospective review**: review of health care services after they have been provided (such as may occur with an emergency room visit to a non-network provider); and
4. **Case Management**: a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the County work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

Restrictions and Limitations of the Utilization Management Program (Very Important Information):

1. The fact that your Health Care Provider recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Health Care Provider. You should follow whatever course of treatment you and your Health Care Provider believes to be the most appropriate, even if the UM Company does not certify a proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the UM Company.
4. With respect to the administration of this Plan, the County, the Claims Administrator and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as Medically Necessary.

5. **Prior Authorization of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during Prior Authorization varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

PRIOR AUTHORIZATION (PRESERVICE) REVIEW

How Prior Authorization Review Works: Prior authorization is a program administered by the appropriate UM Company that helps Members receive care that is medically necessary, appropriate and cost-effective, including assuring that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are medically necessary. The County wants to ensure that Members understand their benefits and coverage because ultimately, the **Member is responsible for making sure prior authorization is obtained**. In most cases, network providers will contact the Plan on the Member's behalf to initiate prior authorization; however, the Member is ultimately responsible for ensuring that the prior authorization process is followed.

Through the prior authorization process, the Plan is able to:

- Confirm a specific plan of care and Medical Necessity for proposed services;
- Determine if proposed services are likely to be considered a covered benefit of the Plan;
- Ensure coordination of care; and
- Assist Members in understanding coverage and benefits, contracting status of providers, and the financial responsibilities of specific types of services.

This prior authorization process will allow Members and their medical provider(s) to make the most informed decisions for medical care. During the process, the UM Company may request and review medical records, test results, and other information to more fully understand what services are being proposed to be performed.

The Plan has identified procedures for prior authorization that have a high incidence of being ordered or performed in scenarios that are either not Medically Necessary or do not meet standard requirements, do not meet other contractual criteria, or there may be an alternative method of care. It is important as a Member to understand that if the Plan denies coverage of a proposed services, it is up to the Member and the medical provider to determine whether the service will be performed.

Failure to obtain prior authorization will result in a denial of coverage of the service that should have been prior authorized. This penalty applies to all services related to the procedure requiring prior authorization. You can contact the appropriate Utilization Management (UM) Company's staff for additional information regarding the prior authorization process (see the Contact Information Chart in the front of this document).

Here is a chart to explain who is the appropriate Utilization Management Company for Prior Authorization under the County's medical plans described in this document:

Medical Plan Name	Appropriate UM Company for Prior Authorization
Kern Legacy Select (HDHP) Plan	
Medical Plan services	County of Kern Human Resources Division – Kern Legacy Health Plan and Clinix Healthcare
Outpatient Prescription Drugs	WellDyne Rx
Kern Legacy Network Plus Plan	
Medical Plan services	County of Kern Human Resources Division – Kern Legacy Health Plan and Clinix Healthcare
Outpatient Prescription Drugs	WellDyne Rx
EPO Medical Plan	
Medical Plan services	Dignity Health Management Services (DHMS) (formerly Managed Care Systems (MCS))
Outpatient Prescription Drugs	National Pharmaceutical Services (NPS)
POS Medical Plan	
Medical Plan services	Clinix Healthcare
Outpatient Prescription Drugs	WellDyne Rx

The following services require prior authorization (must be pre-approved) BEFORE the services are provided by contacting the appropriate Utilization Management (UM) Company.

Reminder: Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time the service is provided, and any benefit limitations.

NON-EMERGENCY MEDICAL PLAN SERVICES REQUIRING PRIOR AUTHORIZATION TO AVOID NON-PAYMENT OF THE SERVICE
1. Allergy Injections (Immunotherapy)
2. All Surgeries in a Hospital Setting or Outpatient Surgery Center
3. Ambulance for Non-Emergency transportation only.
4. Bariatric Surgery
5. Cardiac: Catheterization, Angioplasty, Stents
6. Cosmetic, Plastic, and Reconstructive Surgery
7. Dental Treatment of Accidental Injury to Teeth
8. Diabetic Equipment over $250 per item
9. Dialysis
10. Drug Testing
11. Durable Medical Equipment (DME) over $250 per item
12. Genetic Testing and Counseling
13. Home Health Care and Home Infusion Therapy services
14. Hospice Care
15. Hospital Inpatient Admissions (Elective). Criteria for admission must be met as well as Medical Necessity for concurrent/continuing stay. Note: in accordance with law, for pregnant women, prior authorization is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section. See the section of this chapter on notification to the Plan of an emergency hospitalization.
16. Hyperbaric Medicine
17. Inpatient Mental Health and Substance Use Disorder Treatment in an acute hospital
18. Intensive Outpatient Program and Partial Hospitalization (Mental Health/Substance Abuse Treatment)
19. Intravenous injections outside of an inpatient setting. These injectables require prior authorization: Botox, testosterone, joint injections.
20. Oral Surgery
21. Organ and Tissue Transplants
22. Out-of-area (non-network) Specialist when enrolled in the Kern Legacy Select, Network Plus or EPO plans
23. Outpatient Surgery in a hospital–based surgery center or free-standing outpatient surgicenter. Some procedures do not require authorization when provided by the Plan's appropriate network provider.
24. Pain Management
25. Podiatry Services
26. Prosthetics and Orthotics over $250 per item
27. Radiology Services : Angiogram, CT scans, MRI / MRA, Angioplasty, Discogram/myelogram, PET scan, CT angiography, Embolization, Thallium. No prior auth required for routine plain film x-rays, most ultrasounds, and routine mammograms.
28. Radioallergosorbent (RAST) allergy testing
29. Rehabilitative Services. Including but not limited to Physical therapy, Occupational therapy, Speech therapy, Cardiac rehab., Neurocognitive rehab. and Pulmonary rehab.
30. Residential Treatment Program
31. Specialist Referrals for Initial Consultation for both the Kern Legacy Network Plus Specialist Providers under the EPO Benefit Tier, and Kern Legacy Select Network Specialist Providers and the County of Kern EPO Plan. Specialist referral requirements do not apply to OB/GYNs, Chiropractors or to Outpatient Mental Health or Substance Use Disorder treatment. Note that if a MCS network chiropractor determines you need more than 5 visits, the chiropractor will seek authorization from MCS.
32. Specialty follow-up visits after initial consultation under the Kern Legacy Select, Kern Legacy Network Plus EPO and Plus Benefit Tiers, and the EPO Medical Plan.
33. Skilled Nursing Facility admission.

NON-EMERGENCY MEDICAL PLAN SERVICES REQUIRING PRIOR AUTHORIZATION TO AVOID NON-PAYMENT OF THE SERVICE
34. Sleep Studies
35. Stereotactic Radiosurgery Procedures, such as cyber knife and gamma knife procedures
36. TMJ syndrome/dysfunction treatment
37. Transplantation services (Organ and Tissue) including transplant-related travel expenses
38. Varicose Vein Procedures
39. For individuals who plan to participate in a clinical trial, Prior Authorization is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
OUTPATIENT PRESCRIPTION DRUG SERVICES REQUIRING PRIOR AUTHORIZATION TO AVOID NON-PAYMENT OF THE DRUG
40. For outpatient drugs requiring prior authorization, contact the Prescription Drug Benefit Manager (listed on the Contact Information Chart in the front of this document)
41. Injectable Drugs for home use (Contact the Prescription Drug Program for Prior Authorization)

Some of the above services **can be performed without prior authorization in the appropriate emergency or urgent care facility**, if the services are used for immediate care required to treat a life-threatening Medical Emergency (e.g. sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions).

There is no requirement to obtain prior authorization for the use of a hospital-based emergency room visit.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the Utilization Management program before you are admitted. If this happens, **the appropriate Utilization Management program must be notified of the hospital admission within 48 hours of the admission.** You, your Health Care Provider, the hospital, a family member or friend can make that phone call to Utilization Management program. This will enable the Utilization Management program to assist with your discharge plans, determine the need for continued medical services, advise your Health Care Providers of the various Network support providers and benefits available for you, and offer recommendations, options and alternatives for your continued medical care.

How to Request Prior Authorization (Pre-service Review):

> **REMINDER: It is YOUR RESPONSIBILITY to assure that Prior Authorization occurs when it is required by this Plan. Any penalty for failure to obtain prior authorization is on you, not the Health Care Provider**.

You or your Health Care Provider must call the appropriate UM Company at the telephone number shown in the Contact Information Chart in the front of this document.

1. **Calls for elective services should be made BEFORE the expected date of service.**
2. The caller should be prepared to provide all of the following information: the employer's name, employee's name, patient's name, address, and phone number and social security number; Health Care Provider's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to precertify, **if the preservice review process was not properly followed** the caller will be notified as soon as possible but no later than 5 calendar days after your request.
4. If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Health Care Provider and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Health Care Provider **no later than 15 calendar days after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. **Note that an approved Prior Authorization does not guarantee payment of benefits. This could be for a variety of reasons such as: the information submitted during Prior Authorization varies from the actual services performed on the date of service, the service performed is not a covered benefit, and/or you are ineligible for benefits on the actual date of service.**
6. If your admission or service is determined not to be Medically Necessary, you and your Health Care Provider may be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information chapter regarding appealing a UM determination.
7. If you do not receive the prior authorized service within 60 days of the certification, or if the nature of the proposed service changes, a new Prior Authorization must be obtained.

CONCURRENT (CONTINUED STAY) REVIEW (For The Legacy Medical Plans And The EPO Medical Plan)

How concurrent (continued stay) review works:

1. When you are receiving medical services in a hospital or other inpatient health care facility, the UM Company will monitor your stay by contacting your Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Health Care Providers of various options and alternatives for your medical care available under this Plan.
3. If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Health Care Provider will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense.

RETROSPECTIVE (POST-SERVICE) REVIEW

Claims for certain medical services or supplies be subject to retrospective (post-service) review to determine if they are Medically Necessary or meet the requirements to be a payable benefit under the Plan. For example, a post-service claim for an emergency room visit to a non-network provider may be reviewed retrospectively.

CASE MANAGEMENT

Sometimes navigating the world of health care is confusing and a bit overwhelming. It's helpful to have a knowledgeable professional guide (a case manager) to help you and your family through the maze of health care options, decisions and confusing health care terms. Case management support services may be particularly helpful for patients who require complex, high-technology health care services.

How Case Management Works: Case Management is a voluntary process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the County to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See the section titled Restrictions and Limitations of the Utilization Management Program in this chapter.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown on the Contact Information Chart in the front of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Health Care Provider, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and locating Network providers, as needed. From time to time, the Case Manager may confer with your Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Health Care Provider may call the Case Manager of the Utilization Management Company at any time at the telephone number shown on the Contact Information Chart in the front of this document to ask questions, make suggestions, or offer information.

Under this Plan, if during the course of case management, the case manager identifies opportunities that may result in savings to the member or the Fund, the case manager will present these opportunities to the Plan for their consideration.

APPEALING A UM DETERMINATION (APPEALS PROCESS)

You may request an appeal of any adverse review decision made during the Prior Authorization, Concurrent review, or Case Management described in this chapter. To appeal a denied preservice, urgent, concurrent care or post-service claim/bill, see the Claim Filing and Appeal Information chapter of this document.

MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by all the Medical Plans** in this document (unless otherwise specified as applicable to a certain Medical Plan). Where a certain Medical Plan may offer coverage or partial coverage, the exclusion is noted accordingly. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusions.

GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, Administrative Charges, etc.:** Expenses for preparing or completing forms or for retrieving medical records, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/direct primary care fees, membership/administrative/access/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees, provider stand-by charges, holiday or overtime rates, specific medical reports including those not directly related to the treatment of the member including but not limited to employment or insurance physicals and reports prepared in connections with litigation.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, vocational testing/training, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices. Note that certain educational services may be listed as a covered benefit in the Schedule of Medical Benefits.
4. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation Maximum Plan Benefit as described in the Medical Expense Benefits chapter and Schedule of Medical Benefits section of this document.
5. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
6. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
7. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
8. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational or Unproven as defined in the Definitions chapter of this document.
9. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
10. **Illegal Act:** Treatment of sickness or injury sustained during commission, or attempted commission, of an assault or felony, or injuries sustained while engaging in an illegal occupation, unless such injury or illness is the result of domestic violence, or the commission or attempted commission of an assault or felony, is the direct result of an underlying health factor. This exclusion does not apply if you were the victim of a crime.
11. Expenses for **care/services/supplies required while incarcerated** in, or in the custody of, a federal, state, or local penal institution, or a law enforcement agency.

12. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document. Medically Necessary includes preventive services as noted in the Preventive Services row of the Schedule of Medical Benefits in this document.

13. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, shower/tub grab bars, chair lifts, ceiling mounted lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, electric heating units, etc.

14. **No-Cost Services/No Obligation to Pay:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay (has no obligation to pay), or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan, or for which the Covered Individual is not billed by the health care provider.

15. **Services Not Prescribed by a Physician/Health Care Practitioner**: Expenses for services/supplies that are not ordered, recommended, prescribed or approved by a Physician (or other covered Health Care Practitioner).

16. Services **billed by a Physician or nurse who is an employee of a Hospital** or Skilled Nursing Facility and paid by the Hospital or facility for the service.

17. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those expenses have been prior authorized by the appropriate UM Company and approved by the Plan.

18. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

19. **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene, or beautification including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals or beds, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, admission or bedside kits, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, or private room (only as Medically Necessary), etc.

20. **Physical Examinations, Tests, Immunizations for Employment, School, etc.:** Expenses for physical examinations, screenings, testing and immunizations required for functional capacity/job analysis examinations and testing required for employment/career, commercial driving, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, required by any third party, education, travel, marriage, adoption, judicial or administrative proceedings/orders, medical research or to obtain or maintain a license of any type. The Plan does cover ACA mandated preventive services including physical examination and CDC-recommended immunizations as explained in the Preventive Services row of the Schedule of Medical Benefits.

21. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is Medically Necessary as determined by the Plan Administrator or its designee.

22. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions chapter of this document.

23. **Services Performed Outside the Plan's Network Area**: For the County of Kern Medical plans that require coverage of benefits within the network, expenses for services performed outside the Plan's network are excluded, except these Plans cover emergency services in an emergency room, use of an urgent care facility, and Plan-approved referrals to a non-network provider.

24. **Expenses directly related to complications of a non-covered service:** complications directly related to a non-covered procedure, surgery or service (such as cosmetic services, treatment, or surgery), as determined by the Plan Administrator or its designee, are not covered. This exclusion applies even if the original non-covered procedure, surgery or services were performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the non-covered procedure, surgery or service and would not have taken place in the absence of the non-covered procedure, surgery or service. This exclusion does not apply to conditions including, but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of comorbid conditions.

25. Expenses for a non-hospital **wilderness therapy program**, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care, group home, half-way/quarter-way house, or sober living/transitional living environment.

26. Expenses for **biofeedback** (meaning the technique of using monitoring devices to furnish information regarding an autonomic bodily function, such as heart rate or blood pressure, in an attempt to gain some voluntary control over that function).

27. Expenses for **hypnosis/hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness).

28. **Holistic care**, except as provided under the Chiropractic benefits of the plan.

29. Expenses for **equine (horse) assisted therapy**.

30. Expenses for educational services related to **reading, learning disorders, dyslexia, educational delays, or vocational disabilities**.

31. Expenses for **court-ordered services or services ordered as a condition of parole or probation,** unless the services are both Medically Necessary and a covered benefit of the Plan; **parental custody services; or adoption services**.

32. Expenses for **Applied Behavioral Analysis (ABA) Therapy** (as defined in the Definitions chapter of this document) and related services.

33. Expenses for and related to **service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.

34. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

35. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.

36. Expenses related to a nursing home (that is not a skilled nursing facility), an **assisted living arrangement**, or a **memory care/dementia care facility,** or place for the aged, including services or supplies provided by an institution that is not a legally-operating hospital or a Medicare-approved skilled nursing facility, or other properly licensed facility specified as covered in this Plan document.

37. **Admission for Non-Inpatient Services**: Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not required to be performed on an inpatient basis.

38. Any item, care, service, treatment or expense **not specifically listed as covered** in the Schedule of Medical Benefits.

39. Where **services or supplies require authorization by the Plan** and that authorization is not obtained in a timely manner, the services or supplies are not covered.

40. Services **performed by a person who ordinarily resides in the Member's home** or is related to the Member as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. **Allergy/Alternative/Complementary Health Care Services Exclusions**.

1. Expenses for acupuncture treatment, acupressure or massage to control pain, treat illness, or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points
2. Expenses for chelation therapy, except the Plan covers Medically Necessary treatment of heavy metal poisoning.

B. **Corrective Appliances, Durable Medical Equipment (DME) and Nondurable Supplies Exclusions**.

1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document. No coverage for air purifiers, swimming pools, spas, Jacuzzis, whirlpools, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, non-hospital adjustable beds, water beds, blood pressure instruments, scales, elastic bandages or stockings, first aid supplies, electric heating unit, air conditioners, exercise equipment, and hygienic equipment/supplies.
2. Expenses for **replacement of lost, missing, stolen, misused, duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment. See the Corrective Appliances row and Durable Medical

Equipment row of the Schedule of Medical Benefits for information on repair, adjustment, servicing and replacement of a device under certain situations.

3. **The following equipment is not covered**: a). Items determined to be not medically necessary; b). Items obtained without a physician order; c) Items that are deemed personal comfort items (i.e. humidifiers and bath/shower seats); d) Exercise equipment, sports equipment, equipment intended to enhance athletic ability and hygienic equipment; e) More than one DME device designed to provide essentially the same functional assistance.
4. Replacement of braces for the leg, arm, back, or neck or replacement artificial prosthetic devices such as eyes, arms or legs, unless there is sufficient change in the Member's physical condition or the age of the brace or prosthetic device makes original brace or prosthetic device no longer functional.
5. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
6. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
7. Expenses for **nondurable supplies and disposable supplies,** except certain services are payable as listed in the Nondurable Supplies row in the Schedule of Medical Benefits.

C. **Cosmetic Services Exclusions**.

1. Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens, and other drugs, services and supplies to enhance appearance or beautification, or treatment relating to the consequences of, or as a result of Cosmetic Surgery are not covered, except as required by law. This exclusion includes, but is not limited to, surgery to correct gynecomastia, breast augmentation procedures, surgery to shape/position or proportion the ear (otoplasties), reduction mammoplasty and services for the correction of breast asymmetry, unless otherwise indicated as a payable benefit in the Schedule of Medical Benefits, such as relates to breast reconstruction after a mastectomy.

   A treatment will be considered cosmetic for either of the following reasons:
   - The primary purpose is to enhance or beautify.
   - There is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, injury, or congenital abnormality.

   The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).
2. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. Cosmetic surgery or treatment includes surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, but not to treat physical function.

   No benefits are available for surgery or treatments to change the texture or look of the skin or to change the size, shape or look of facial or body features (including but not limited to the nose, eyes, ears, cheeks, chin, chest or breasts). No benefits are payable for procedures to remove excess skin after weight loss, including body contouring or panniculectomy.
3. Blepharoplasty (surgical modification of the eyelid) is covered if deemed medically necessary by the Plan, but is not covered for cosmetic reasons such as lower eyelid blepharoplasty to improve puffy eyelid "bags" and/or to reduce the wrinkling of skin.

   Note: The Medical Program does cover Medically Necessary Reconstructive Services. Reconstructive Surgery is payable only if required by law (e.g., breast symmetry after a mastectomy), or the procedure or treatment is intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital anomaly (birth defect) or covered surgery. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Plan Participants should use the Plan's Prior Authorization procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or will be considered as a Medically Necessary Reconstructive Service.
4. Cosmetic Surgery or Treatment that is not covered includes, but is not limited to:
   - removal of tattoos, ear or body piercing, electrolysis hair removal
   - breast augmentation or mastopexy (except the Plan covers reconstructive services after a mastectomy),
   - breast reduction (including treatment of benign gynecomastia in males),
   - removal of redundant or excessive skin including elimination of redundant skin of the abdomen, abdominoplasty,
   - surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance,
   - treatment of varicose veins,
   - skin resurfacing, body sculpting, chemical skin peel, cosmetic skin products such as Restylane and Renova, collagen and other filler injectable products such as Juvederm, Perlane, Radiesse,

- face/forehead/brow/eyelid/neck lift, upper eyelid blepharoplasty, nose/lip/cheek/malar/chin enhancement, reduction or implant, facial bone reduction,
- calf/buttocks/pectoral implants/lift/augmentation,
- liposuction body contouring,
- reduction thyroid chondroplasty,
- voice modification surgery (laryngoplasty or shortening of the vocal cords), voice therapy/voice lessons,
- drugs for hair loss, hair growth, hair removal, hair implantation,
- or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cosmetic surgery does not become reconstructive surgery because of psychological reasons.

D. **Custodial Care Exclusions**.

1. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, domiciliary care, rest cures, maintenance type care that is not reasonably expected to improve the patient's condition, adult day care, child day care, services of a homemaker, or housekeeper, or personal care, sitter/companion/caregiver service, home health aides, (except when Custodial Care is provided as part of a covered Hospice program or is provided during a covered hospitalization). Services and supplies that are provided to primarily assist with activities of daily living (ADL) are not covered.
2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.

E. **Dental Services Exclusions**.

1. Expenses for Dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth, jaw or another part of the body, including but not limited to dental cleaning, dental x-rays, fillings, crowns, root canal, periodontal treatment, crowns, inlays, onlays, bridgework, dental appliances, cosmetic dental services dental prosthetics, splints, retainers, oral appliances, orthodontia services, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth. No coverage for removal of wisdom teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth (except the Plan covers dental services under the benefit for Treatment of Accidental Injuries to the Teeth explained in the Oral services row of the Schedule of Medical Benefits).
2. Expenses for Dental services related to any injury caused by biting or chewing.
3. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, Temporomandibular Joint dysfunction/syndrome or other cosmetic reasons.

F. **Drugs, Medicines and Nutrition Exclusions**.

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route, duration and frequency for which they are prescribed (*i.e.* are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
2. Non-prescription (or non-legend or over-the-counter - OTC) drugs or medicines, except that the Plan covers insulin and syringes, certain OTC antihistamines and proton pump inhibitors, and certain OTC and prescription medication in accordance with ACA regulations at no cost when prescribed by a Physician or Health Care Practitioner and filled at a network pharmacy. See the Drugs row in the Schedule of Medical Benefits.
3. Foods and nutritional/dietary supplements including, but not limited to, solid or liquid food, food substitutes, food supplements, standard or specialized infant formula, banked breast milk, electrolyte solutions, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except that the following are payable:
   (a) foods and nutritional supplements provided during a covered hospitalization or covered health care facility admission,
   (b) when prescribed in compliance with ACA regulations such as prenatal vitamins for females,
   (c) nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole or primary means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration such as total parental nutrition/TPN) and is not considered a food thickener, infant formula, specialized infant formula, donor breast milk, baby food, or other non-prescription product/substance that can be mixed in a blender.

4. The following drugs, medicines or devices:
   (a) anabolic steroid injections and injectable drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance;
   (b) compound drugs are excluded under the Kern Legacy Select Plan and the Kern Network Plus Plan and the POS Medical Plan. (Compound drugs are covered under the EPO Medical plan);
   (c) cosmetic products such as Restylane and Renova and collagen and other filler injectable products such as Juvederm, Perlane, Radiesse,
   (d) fertility drug products or agents;
   (e) growth hormone and growth/height promotion drugs. (These drugs are covered under the EPO plan with prior authorization);
   (f) hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   (g) hypodermic syringes and needles except the Plan covers needles and syringes for administration of insulin and other covered injectable drugs;
   (h) male contraceptives, such as condoms;
   (i) any form of marijuana, medical marijuana and marijuana based products, oils and./or consumables. (The plans do cover FDA approved tetrahydrocannabinol (e.g. Marinol);
   (j) replacement prescription refills for lost, stolen or damaged drugs;
   (k) drugs entirely consumed at the time and place of prescribing;
   (l) drugs distributed as manufacturer samples.
5. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
6. This Plan has adopted the Prescription Drug Program's current formulary, including its preferred drug list, as the Plan's covered formulary of covered drugs. Based on the Prescription Drug Program's formulary (which is updated from time to time), certain drugs are not covered by the Plan, or are covered only when they have been prior authorized by the Prescription Drug Program. Contact the Prescription Drug Program for information about the formulary or Drug Exception Process (a process allowing a member's physician to contact the Prescription Drug Manager to request that a non-covered drug be payable under the Plan).

G. **Durable Medical Equipment (DME) Exclusions**.

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

H. **Fertility and Infertility Services Exclusions**.

1. For the POS Plan, **no coverage for infertility diagnosis, testing or treatment**.
2. For the **Kern Legacy Select Plan and the Kern Network Plus Plan and EPO Medical plan**, no coverage for the **treatment of infertility** or expenses to enhance the possibility of reproduction, along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility; **in vitro fertilization (IVF)**; low tubal transfer; **artificial insemination**; embryo transfer; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); collection/storage/purchase of donor egg/semen; cryostorage (freezing) of egg/sperm; ovarian transplant; infertility donor expenses; fetal implants; fetal reduction services; surgical impregnation procedures; and reversal of sterilization procedures.
3. Expenses for and related to **adoption**.

I. **Foot Care/Hand Care Exclusions**.

1. Expenses for **routine foot care**, (routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition and sensation). Routine foot care administered by a licensed medical professional including a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
2. **Non-surgical treatment of deformities of the toes and feet**, including treatment of flat feet, fallen arches, weak feet, chronic foot strain, **foot orthotics**, and asymptomatic complaints related to the feet. Note that the Plan covers Podiatric (foot) appliances for prevention of complications of diabetic nerve conditions (limited to one (1) pair per calendar year). Foot orthotics that are not incorporated into a cast, splint, brace or strapping of the foot are not covered.
3. Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand.

J. **Genetic Testing and Counseling Exclusions**.

1. Genetic testing is excluded from coverage, except as listed as a covered benefit in the Genetic services row of the Schedule of Medical Benefits. All other types of genetic testing are not covered including genetic testing for routine pregnancy (unless mandated by law), home genetic testing and paternity testing. Also, no coverage for:
   a) pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents.
   b) genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan.
   c) genetic testing that is not listed as a covered benefit in the Genetic services row of the Schedule of Medical Benefits.
2. Genetic counseling is not covered unless the genetic testing is a covered benefit.

K. **Hair Exclusions**.

1. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, hairpieces, hair cranial prosthesis, or hair analysis. Except that the Medical Plans will provide benefits for a wig as explained in the Corrective Appliances row of the Schedule of Medical Benefits.

L. **Hearing Care Exclusions**.

1. Expenses for and related to examinations for placement/fitting of an external hearing aid, the purchase, servicing, fitting and/or repair of **external hearing aid devices** (device that amplifies sound), including replacement parts, lost, stolen or missing hearing aids, hearing aid batteries and other hearing aid supplies and accessories including Dri-Aid kits for hearing aid moisture removal and phone ear pads. (Note that the Plan covers medically necessary iimplantable hearing devices (e.g. cochlear implant) for individuals with a hearing loss of 71 or more decibels.)
2. No coverage for use of implantable hearing devices for conditions deemed experimental and investigational.
3. No coverage for external hearing aids, non-osseointegrated hearing devices, and examinations for placement/fitting of an external hearing aid or hearing aid supplies.

M. **Home Health Care Exclusions**.

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies.
2. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, child care, adult day care, caregiver or personal care attendant services, except as provided under the Plan's Hospice coverage.

N. **Maternity/Family Planning/Contraceptive Exclusions**.

1. Expenses related to contraceptive drugs and devices for males, such as condoms.
2. **Termination of Pregnancy:** Expenses for elective induced abortion except as covered under the Maternity row in the Schedule of Medical Benefits.
3. Expenses for **childbirth education, Lamaze classes**.
4. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**
5. **Pre-planned home birth.**
6. With respect to a surrogacy arrangement, no coverage for maternity or delivery expenses of a woman who is not a covered plan participant.

For Nondurable supplies (see Corrective Appliances).

O. **Nursing Care Exclusions**.

1. Expenses for services of private duty nurses or other private duty health care personnel.

P. **Rehabilitation Therapy Exclusions (Inpatient or Outpatient)**.

1. Expenses for educational, job training, vocational rehabilitation, or recreational therapy.
2. Charges made for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision of this Plan. See Rehabilitation Services row in the Schedule of Medical Benefits.
3. Expenses for massage therapy, rolfing (deep muscle manipulation and massage) and related services.

4. Physical therapy (PT), Occupational therapy (OT), and Speech therapy (ST) is not covered when services are the result of the following: Psychosocial speech delay (including delayed language development); perceptual and conceptual dysfunctions; or Developmental articulation and language disorders (e.g. stuttering, stammering).
5. Speech Therapy is not covered for remedial or educational purposes or for initial development of natural speech. This exclusion applies to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy is considered educational in nature and not eligible for coverage. Speech therapy is not covered for these conditions, including, but not limited to: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering/stammering, and voice defects of pitch, loudness, and quality. Online telespeech therapy is not covered.
6. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development.
7. Expenses listed as not covered in the Rehabilitation row of the Schedule of Medical Benefits.
8. Expenses for Aquatic/hydro (water based) therapy, Group physical therapy, Group occupational therapy and Group speech therapy.
9. Expenses for Maintenance Rehabilitation (as defined under Rehabilitation in the Definitions chapter of this document).

Q. **Sexual/Erectile Dysfunction Services Exclusions**.

1. **Treatment of Erectile Dysfunction (Impotency)**: Expenses for medical devices, medical treatment or surgical treatment of erectile dysfunction or inadequacy including but not limited to implants, devices or preparations to correct or enhance erectile function, sensitivity, or alter the shape or appearance of a sex organ. The Plan does cover drugs to treat erectile dysfunction (see the Drugs row in the Schedule of Medical Benefits).
2. **Treatment of Gender Dysphoria/Gender Incongruence:** Expenses for medical, surgical or prescription drug treatment related to treatment of gender dysphoria/gender incongruence including transgender/transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures or reversal of any such procedures.

R. **Transplant (Organ and Tissue) Exclusions**.

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications. See the Transplant Services row of the Schedule of Medical Benefits for payable transplant services.
2. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.
3. No benefits will be provided for a pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the Member has received a kidney transplant.

S. **Transportation**.

1. Air ambulance will not be covered if the Member is taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if the Member is taken to a Physician's office or home.
2. Ambulance and non-emergency transportation services are not covered when: another type of transportation can be used without endangering the member's health; for convenience of the member or the convenience of the family or doctor; or for trips to a Doctor's office or clinic, a morgue or funeral home.
3. Non-emergency ambulance or medical transportation services deemed Not Medically Necessary by the Plan.

T. **Vision Care Exclusions**.

1. Expenses for **surgical correction of refractive errors** (such as near-sightedness called myopia, far-sightedness called hyperopia, or astigmatism) and refractive keratoplasty procedures for the improvement of vision when vision can be corrected through the use of eyeglasses or contact lenses. This exclusion includes but is not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser-Assisted In-Situ Keratomileusis (LASIK) or implantable contact lenses (ICL).
2. Expenses for **treatment of refractive errors**, including eye examinations, purchase, fitting and repair of eyeglasses or lenses or contact lenses and associated supplies, except the Plan covers one pair of eyeglasses or contact lenses as a Prosthetic device following ocular surgery to remove the lens of the eye such as with a cataract extraction as explained in the Corrective Appliances row in the Schedule of Medical Benefits. Note that the Kern Legacy Select and Kern Legacy Network Plus and EPO plan covers an eye examination to determine the need for correction of vision.
3. Vision therapy (orthoptics) and supplies.

U. **Weight Management and Physical Fitness Exclusions**.

1. Expenses for **medical weight loss programs** (e.g. Weight Watchers, Jenny Craig, meal replacement food/drinks), and **skin reduction procedures/treatment** following weight loss. See also the Plan's coverage for screening and intensive behavioral counseling for obesity under the Preventive Services row and the Bariatric surgery row in the Schedule of Medical Benefits and coverage for weight reduction drugs under the outpatient prescription drug benefit.
2. Expenses for memberships in or visits to **health clubs, exercise programs**, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, ergonomic chairs/desks, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

CLAIM FILING AND APPEAL INFORMATION

This chapter describes the procedures for filing claims for certain benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by the procedures in this chapter include those claims filed and appeals related to the self-funded Medical Plan(s) (including the Prescription Drug Program).

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO.

WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid; or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to

a. recover overpayments from the entity to which the overpayment was made, or on whose behalf it was made; or from the participant directly;

b. a refund from you or your Health Care Facility or Health Care Provider/Practitioner for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

c. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or

d. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

TIME LIMIT FOR INITIAL FILING OF MEDICAL PLAN CLAIMS

All claims must be submitted to the Plan within ONE YEAR from the date of service.
No Plan benefits will be paid for any claim submitted after this period.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information.
The Plan is not legally required to consider information submitted after the stated timeframe.

COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services.

Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter for more information.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable only if the Plan approves payment before you receive the services. These benefits are referred to as pre-service claims (also known as prior authorization). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby. See the Utilization Management chapter for more details.

COMPLYING WITH MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

KEY DEFINITIONS RELATED TO CLAIMS AND APPEALS

You should refer to these definitions below when reviewing particular claim filing and appeal information in this claims/appeals section:

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for a health care claim is defined as:

- a denial, reduction, termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a Rescission of coverage whether or not there is an adverse effect on any particular benefit at that time.

Appropriate Claims Administrator: The various organizations under contract to the Plan to perform claims adjudication services to administer health claims and/or claim appeals. "Claims Adjudication" refers to the determination of the Plan's payment or financial responsibility, after the plan participant's benefits are applied to a claim.

Claims are adjudicated by several different claims administrators depending on which type of benefit is being sought. The organizations that administer each type of health claim (the Appropriate Claims Administrator) are outlined in the chart below. (For contact information for each claims administrator, see the Contact Information Chart in the front of this document.)

Appropriate Claims Administrator	Type of Claim Processed	Urgent Appeal	Concurrent Appeal	Pre-service Appeal	Post-Service Appeal	Level of Appeal for all medical plans except the EPO plan	Level of Appeal for the EPO plan
Medical Plan Claims Administrator	Eligibility and Post-service claims	NA	NA	NA	X	Level One to the Medical Plan Claims Administrator. Voluntary appeal to the County of Kern.	Level One to the Medical Plan Claims Administrator.
Utilization Management Company	Urgent, concurrent and preservice claims	X	X	X	NA	Level One to the Utilization Management Company. Voluntary appeal to the County of Kern.	Level One to the the Utilization Management Company
Pharmacy Benefit Manager for the Outpatient Prescription Drug Program	Outpatient drug urgent, concurrent, preservice, and post-service claims	X	X	X	X	Level One to the Outpatient prescription drug Claims Administrator. Voluntary appeal to the County of Kern.	Level One to the the Outpatient prescription drug Claims Administrator.

Authorized Representative: This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan).

An authorized representative under this Plan can include a network Health Care Professional. Under this Plan you do not need to designate in writing that the Network Health Care Professional is your authorized representative if that Health Care Professional is part of the claim appeal. Under this Plan non-network providers cannot automatically be designated to be an Authorized Representative. Instead, the plan participant must make a written designation if they desire a non-network provider to be their authorized representative for a claim appeal; however, this designation does not extend to permit the non-network provider to file legal action on behalf of the participant or their claim appeal. The written Authorized Representative request should include the plan participant's name and contact information along with the authorized representative's name, address and phone number. The authorized representative request should be submitted to the Medical Plan Claims Administrator.

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g*. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual or the circumstances of the authorized representative or its process appear to be defective, fraudulent or otherwise invalid.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter.

There are **four types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent, and Post-service,** described later in this section. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
b. be **received by the Appropriate Claims Administrator** as that term is defined in this chapter;
c. **name a specific individual including their social security number, Medicare HICN number or Medicare beneficiary identifier (MBI)**,
d. **name a specific medical condition or symptom**,
e. **name a specific treatment, service or product** for which approval or payment is requested,
f. **made in accordance with the Plan's claims filing procedures described in this chapter**; and
g. **includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits**.

A claim is NOT:

a. a request made by **someone other than** the individual or his/her authorized representative;
b. a request made by a **person who will not identify himself/herself** (anonymous);
c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
g. a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a network pharmacy.

h. a **request for an EAP visit** (at no charge) which is beyond the number of EAP visits payable by the Plan per year.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Days: For the purpose of the claim filing and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require prior authorization are listed in the Prior Authorization chapter in this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing prior authorization (that were obtained without prior approval) if the patient was unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (prior authorization) procedure could have seriously jeopardized the patient's life or health.

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for prior authorization, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require prior authorization are listed in the Prior Authorization chapter in this document.

REVIEW OF ISSUES THAT ARE NOT A CLAIM (AS DEFINED IN THIS CHAPTER)

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Plan Administrator (whose contact information is listed on the Contact Information Chart in the front of this document). The request will be reviewed and the participant will be advised of the decision within 60 days of the receipt of the request.

FILING A POST-SERVICE CLAIM

Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim or bill usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim. Generally, network Health Care Providers send their bill directly to the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since a written or electronic claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a written or electronic claim must be filed with the Plan (called a "Post-service Claim"). At that time, a determination will be made as to if, and what benefits are payable under the Plan.

- When care is provided by a Network provider, the provider will file a claim with the Plan on the member's behalf; members need not contact anyone.

- When care is provided by a Non-network provider such as in the case of an emergency, the provider may send the member the claim, in which case the member should send a copy of that claim to the Appropriate Claims Administrator.
- If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if a plan maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.

Claims are reviewed and paid by the Appropriate Claims Administrator in accordance with the rules and provisions contained in this Plan document. In all instances, when deductibles, coinsurance or copayments apply, the member is responsible for paying their share of the covered charges.

Proof Needed In Order to Process Claims:

1) When processing claims submitted on behalf of a Newborn Dependent Child, the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (e.g. copy of certified birth certificate for newborn).
2) When processing claims submitted on behalf of a Dependent Child who is age 26 or older, the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. disabled adult child verification).
3) If claims are submitted on behalf of a Dependent child for whom the Plan has not yet received proof of dependent status, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
4) When processing claims submitted on behalf of a new Spouse, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).
5) When processing claims related to an accident, the Appropriate Claims Administrator will need information about the details of the accident in order to consider the claim for payment.

Timely Claim Submission: Claims for benefits should be submitted to the Appropriate Claims Administrator within ninety (90) days after the date of service, but **no later than one (1) year after the date of service**, in order to be considered for payment by the Plan.

Post-Service claims should be submitted to the Appropriate Claims Administrator, (see the Contact Information Chart for addresses).

For claims incurred outside the U.S. (foreign claims), in most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document. If the provider located outside the U.S. does not require payment at the time of service, when such claims are determined to be payable by this Plan, payment for covered services will be sent to the plan participant. Foreign claims will be processed like any other non-network claim. The claims administrator will have the claim translated into English and then will determine the daily rate of exchange between the U.S. dollar and the applicable foreign currency (based on the rate of exchange quoted on www.oanda.com on the date when the treatment or services were received). Then payment will be made to you so that you can forward payment to the appropriate provider outside the U.S. Payment is not made by this Plan to a provider outside the U.S.

If the claim submitted by a provider is denied in whole or in part, for any reason, the member and health care provider will be notified of the denial as described below in more detail.

FILING A POST-SERVICE CLAIM

When a post-service claim is submitted to the Appropriate Claims Administrator, that Appropriate Claims Administrator will review your post-service claim no later than **30 calendar days** from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.

a. This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
b. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.
c. The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

If the post-service claim is approved, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

If the post-service claim is denied in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) along with the Explanation of Benefits or EOB form. This notice of initial denial will:

a. identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);

c. give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

g. provide an explanation of the Plan's internal appeal procedure and external review processes (when external review is applicable) along with time limits and information regarding how to initiate an appeal;

h. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

i. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

j. disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

SPANISH (Español): Para obtener asistencia en Español, llame al TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa CHINESE (中文): 如果需要中文的帮助，请拨打这个号码	• **Kern Legacy Select Plan**: (661) 868-3280 or 1 (855) 308-5547, select option 1 then 1 to be routed to the Medical Plan Claims Administrator. • **Kern Network Plus Plan**: (661) 868-3280 or 1 (855) 308-5547, select option 1 then 1 to be routed to the Medical Plan Claims Administrator. • **EPO Plan**: 661-716-3450 or 888-587-8810. • **POS Plan**: 1 (855) 537-6767, select option 1 then 3 to be routed to the Medical Plan Claims Administrator.

If you disagree with a denial of a post-service claim, you or your authorized representative may ask for a post-service appeal review. **You have 180 calendar days following receipt of an initial denial to request an appeal review**. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal of a Denial of a Post-Service Claim

This Plan maintains a 2-level appeal process for the Kern Legacy Select, Kern Legacy Network Plus and the POS Medical Plans and a 1-level appeal process for post-service claims uner the EPO Plan. Appeals must be submitted in writing to the Appropriate Claims Administrator (contact information listed on the Contact Information Chart in the front of this document). You will be provided with:

a. upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

b. the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

c. a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

d. automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

e. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

f. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

g. a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:

a. consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

b. provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

Under this Plan's 2 level appeal process, the Appropriate Claims Administrator will make the first level determination on the post-service appeal no later than **30 calendar days** from receipt of the appeal. There is no extension permitted in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a **voluntary second level appeal** review by writing to the Plan Administrator whose contact information is listed on the Quick Reference Chart in this document. The Plan Administrator then will make a second level determination no later than **30 calendar days** from receipt of the second level appeal.

You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

You will receive a **notice of the appeal determination** at each level of the appeal review. If that determination is adverse, it will include the following:

a. information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a voluntary second level of appeal or an external review (when external review is applicable);

c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. an explanation of the Plan's voluntary second level appeal (if any) and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

g. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

h. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

i. the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

j. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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This concludes the post-service appeal process under this Plan. This Plan does offer an **additional voluntary appeal** to the to plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans, or you can proceed with an External Review (the External Review process is described later in this chapter).

Option for a <u>Voluntary Appeal</u> for plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans: This Plan does offer an additional voluntary claim appeal option after the Level 1 claim appeal process is completed.

a) Submit your written request for the voluntary appeal to the County of Kern Plan Administrator (whose contact information is listed on the Contact Information Chart in the front of this document) within 60 days of your receipt of the Level 1 claim appeal determination. You should also submit written comments, documents, medical records and other information relating to the claim for benefits.

b) The Plan will make a determination on the voluntary appeal (without the opportunity for an extension) as soon as possible but no later than 30 days after the Plan's receipt of a request for voluntary appeal.

c) You will be provided with a written notice of the Plan's determination on the voluntary appeal request within 5 days of the date of the Plan's determination on the voluntary appeal.

If the determination is adverse, the notice will list the specific reason(s) for the decision and reference the specific Plan provision(s) on which the denial is based. If your claim is eligible for an External Review, you may proceed to request an External Review after this voluntary appeal option is completed.

FILING AN URGENT CARE CLAIM

If your claim involves urgent care (as defined earlier in this section) as determined by your attending Health Care Professional, you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator (such as the Utilization Management Company or Pharmacy Benefit Manager) whose contact information is listed on the Contact Information Chart in the front of this document.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon

as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.
- If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

You will be notified of the Plan's benefit determination **as soon as possible but no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

If you fail to provide sufficient information to decide an urgent care claim, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

If the urgent care claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

If the urgent care claim is denied in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:

a. identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
b. state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);
c. give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
d. reference the specific Plan provision(s) on which the determination is based;
e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
f. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
g. provide an explanation of the Plan's internal appeal procedure and external review process (when external review is applicable) along with time limits and information regarding how to initiate an appeal, including a description of the **expedited** appeal review process and external review process for urgent care claims (when external review is applicable);
h. a statement of the voluntary Plan appeal procedures, if any;
i. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
j. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
k. disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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If you disagree with a denial of an urgent care claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal of a Denial of an Urgent Care Claim

You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Contact Information Chart in the front of this document. You will be provided with:

a. upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

b. the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

c. a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

d. automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

e. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

f. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

g. a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than **72 hours** after receipt of the appeal.

The **notice of appeal review** of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:

a. information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an external review (when external review is applicable);

c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. an explanation of the Plan's voluntary appeal option and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review;

g. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

h. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

i. the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

j. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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This concludes the urgent care claim appeal process under this Plan. This Plan does offer an **additional voluntary appeal** to the to plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans, or you can proceed with an External Review (the External Review process is described later in this chapter).

Option for a Voluntary Appeal for plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans: This Plan does offer an additional voluntary claim appeal option after the Level 1 claim appeal process is completed.

d) Submit your written request for the voluntary appeal to the County of Kern Plan Administrator (whose contact information is listed on the Contact Information Chart in the front of this document) within 60 days of your receipt of the Level 1 claim appeal determination. You should also submit written comments, documents, medical records and other information relating to the claim for benefits.

e) The Plan will make a determination on the voluntary appeal (without the opportunity for an extension) as soon as possible but no later than 30 days after the Plan's receipt of a request for voluntary appeal.

f) You will be provided with a written notice of the Plan's determination on the voluntary appeal request within 5 days of the date of the Plan's determination on the voluntary appeal.

If the determination is adverse, the notice will list the specific reason(s) for the decision and reference the specific Plan provision(s) on which the denial is based. If your claim is eligible for an External Review, you may proceed to request an External Review after this voluntary appeal option is completed.

FILING A CONCURRENT CARE CLAIM

If your claim involves concurrent care (as that term is defined earlier in this chapter), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator (Utilization Management Company or Pharmacy Benefit Manager) whose contact information is listed on the Contact Information Chart in the front of this document.

If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

The Plan will provide you automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.
- If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.

Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than **3 calendar days** after the oral notice.

If the concurrent care claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:

a. identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);

c. give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

g. provide an explanation of the Plan's internal appeal procedure and external review processes (when external review is applicable) along with time limits and information regarding how to initiate an appeal;

h. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

i. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

j. disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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If you disagree with a denial of a concurrent claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Concurrent Care Claim

You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Pharmacy Benefit manager), whose contact information is listed on the Contact Information Chart in the front of this document. You will be provided with:

a. upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

b. the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

c. a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

d. automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

e. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and

sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

f. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

g. a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

A determination will be made on the appeal (without the opportunity for extension) **as soon as possible before the benefit is reduced or treatment is terminated**.

The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:

a. information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a voluntary appeal option or external review (when external review is applicable);

c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. an explanation of the Plan's voluntary second level appeal (if any) and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

g. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

h. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

i. the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

j. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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This concludes the concurrent claim appeal process under this Plan. This Plan does offer an **additional voluntary appeal** to the to plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans, or you can proceed with an External Review (the External Review process is described later in this chapter).

Option for a Voluntary Appeal for plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans: This Plan does offer an additional voluntary claim appeal option after the Level 1 claim appeal process is completed.

a) Submit your written request for the voluntary appeal to the County of Kern Plan Administrator (whose contact information is listed on the Contact Information Chart in the front of this document) within 60 days of your receipt of the Level 1 claim appeal determination. You should also submit written comments, documents, medical records and other information relating to the claim for benefits.

b) The Plan will make a determination on the voluntary appeal (without the opportunity for an extension) as soon as possible but no later than 30 days after the Plan's receipt of a request for voluntary appeal.

c) You will be provided with a written notice of the Plan's determination on the voluntary appeal request within 5 days of the date of the Plan's determination on the voluntary appeal.

If the determination is adverse, the notice will list the specific reason(s) for the decision and reference the specific Plan provision(s) on which the denial is based. If your claim is eligible for an External Review, you may proceed to request an External Review after this voluntary appeal option is completed.

FILING A PRE-SERVICE CLAIM

A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter. A pre-service claim (claim which requires prior authorization) must be submitted (orally or in writing) to the Appropriate Claims Administrator (Utilization Management Company or Pharmacy Benefit Manager), whose contact information is listed on the Contract Information Chart in the front of this document.

The pre-service claim will be reviewed no later than **15 calendar days** from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request. The 15 calendar day review period **may be extended one time for up to 15 additional calendar days** if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.

a. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.

b. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

c. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.

The Plan will provide you automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.
- If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

If the pre-service claim is approved you will be notified orally and in writing (or electronic, as applicable).

If the pre-service claim is denied in whole or in part, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:

a. identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

b. state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);

c. give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

d. reference the specific Plan provision(s) on which the determination is based;

e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

f. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

g. provide an explanation of the Plan's internal appeal procedure and external review processes (when external review is applicable) along with time limits and information regarding how to initiate an appeal;

h. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

i. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

j. disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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If you disagree with a denial of a pre-service claim, you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Pre-Service Claim

Appeals must be submitted in writing to the Plan Administrator, whose contact information is listed on the Contact Information Chart in the front of this document. You will be provided with:

a. upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

b. the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

c. a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

d. automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

- If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

- a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make a determination on the appeal no later than **30 calendar days** from receipt of the appeal. There is **no extension permitted** to the Plan in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.

If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

You will receive a **notice of the appeal determination**. If that determination is adverse, it will include the following:

a. information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
b. the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);
c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
d. reference the specific Plan provision(s) on which the determination is based;
e. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
f. an explanation of the Plan's voluntary appeal option and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary appeal option, if any;
g. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
h. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
i. the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency" and
j. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Contact Information Chart at the front of this document.):

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This concludes the pre-service appeal process under this Plan. This Plan does offer an **additional voluntary appeal** to the to plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans, or you can proceed with an External Review (the External Review process is described later in this chapter).

Option for a Voluntary Appeal for plan participants enrolled in the Kern Legacy Select, Kern Legacy Network Plus or POS Medical Plans: This Plan does offer an additional voluntary claim appeal option after the Level 1 claim appeal process is completed.

a) Submit your written request for the voluntary appeal to the County of Kern Plan Administrator (whose contact information is listed on the Contact Information Chart in the front of this document) within 60 days of your receipt of the Level 1 claim appeal determination. You should also submit written comments, documents, medical records and other information relating to the claim for benefits.

b) The Plan will make a determination on the voluntary appeal (without the opportunity for an extension) as soon as possible but no later than 30 days after the Plan's receipt of a request for voluntary appeal.

c) You will be provided with a written notice of the Plan's determination on the voluntary appeal request within 5 days of the date of the Plan's determination on the voluntary appeal.

If the determination is adverse, the notice will list the specific reason(s) for the decision and reference the specific Plan provision(s) on which the denial is based. If your claim is eligible for an External Review, you may proceed to request an External Review after this voluntary appeal option is completed.

OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make an **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
Appeal Request must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make an **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	60 days for each level of appeal
Extension permitted during appeal review?	No	No	No	No
Plan offers an additional **voluntary claim appeal** after the denied claim appeal for the Kern Legacy plans and the POS plan?	Yes	Yes	Yes	No, the Plan already permits two levels of appeal
Claimant may be **eligible to pursue an External Review** of the denied claim appeal (See the External Review section of this chapter)?	Yes	Yes	Yes	Yes

[1]: no formal extension for urgent care claims but if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

EXTERNAL REVIEW OF CERTAIN CLAIMS

1. This voluntary External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

2. **External Review is only applicable in certain cases**. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

   (a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational or for a wellness program that includes a health-factor based reward, an adverse review decision or

entitlement to a reasonable alternative standard for reward, or medical judgment for determinations of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act. The IRO will determine whether a denial involves a medical judgment; and/or

(b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

3. **External review is <u>not available</u> for** any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to claims for life/death benefits, AD&D, disability, the Dental Plans, the Vision Plans, or to the Plan's health flexible spending account (FSA).

   There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

4. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, generally, you may only seek external review after a final determination has been made on appeal. See also the section on Deemed Exhaustion of the Plan's Internal Claims and Appeals Procedures.

5. There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims. (Generally post-service claims for external review would follow the standard claim process noted below while urgent claims for external review may follow the expedited urgent claims process noted below.)

6. **External Review of Standard (Non-Urgent) Claims**.

   (a) Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (Level-1 appeal response). For convenience, these claim appeal determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   (b) An external review request on a standard claim should be made to the following appropriate **Plan designee**:

      1) The Medical Plan Claims Administrator, with respect to a denied medical plan claim not involving retail prescription drug expenses;

      2) The Pharmacy Benefit Manager, with respect to a denied claim involving outpatient retail prescription drug expenses;

      3) The Utilization Management Company, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving prescription drug expenses or behavioral health expenses;

   Contact information for the Medical Plan Claims Administrator, the Pharmacy Benefit Manager, and the Utilization Management Company is identified in the Contact Information Chart.

   (c) **Preliminary Review of Standard Claims**.

      1) Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

         i You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

         ii The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

         iii You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

         iv You have provided all of the information and forms required to process an external review.

      2) Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

         i If your request is complete and eligible for external review; or

         ii If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

(d) **Review of Standard Claims by an Independent Review Organization (IRO)**.

1) If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

i The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

ii Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

iii If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

iv The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

v The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

vi The assigned IRO's decision notice will contain:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

b) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

c) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

e) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

f) A statement that judicial review may be available to you; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

7. **External Review of Expedited Urgent Care Claims**.

(a) You may request an expedited external review if:

1) you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

(b) Your request for an expedited external review of a non-standard claim should be made to the following appropriate **Plan designee**:

1) The Utilization Management Company, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving outpatient retail prescription drug expenses;

2) The Pharmacy Benefit Manager, with respect to a denied claim involving retail prescription drug expenses;

Contact information for the Utilization Management Company and the Pharmacy Benefit Manager is identified in the Contact Information Chart.

(c) **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

(d) **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

8. **Overview of the Timeframes During the Federal External Review Process**.

Steps in the External Review Process	**Timeframe for Standard Claims**	**Timeframe for Expedited Urgent Care Claims**
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
• Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
• When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	**In a timely manner**	**Expeditiously**
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

DEEMED EXHAUSTION OF THE PLAN'S INTERNAL CLAIMS AND APPEALS PROCEDURES

If the Plan fails to strictly adhere to its internal claims and appeals requirements, the Plan participant is deemed to have exhausted the Plan's internal claims and appeals process and can initiate a request for a voluntary external review (when external review is applicable) or proceed with legal action.

In accordance with 45 CFR 147.136(b)(2)(ii)(F), a Plan participant is deemed to have exhausted the administrative remedies available to them under the Plan's claim appeal procedures described in this document, and may proceed to initiate an external review (when applicable) or pursue legal action against the Plan where:

1. the initial claim determination was not completed within the required timeframe;
2. the Plan did not give the Plan participant written notice stating the specific reasons for the denial, (written in a manner calculated to be understood by the Plan participant); or
3. the Plan failed to afford a reasonable opportunity to the Plan participant whose claim has been denied, for a full and fair review by the appropriate named Plan fiduciary, or
4. where a court has waived the exhaustion of the Plan's administrative remedies requirement where exhaustion would be futile.

The Plan's internal claims and appeals procedures will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Plan participant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Plan participant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

- The Plan participant may request a written explanation of the violation from the Plan and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted.
- If an external reviewer or a court rejects the claimant's request for immediate review on the basis that the Plan met the standards for the exception, the Plan participant has the right to resubmit and pursue the internal appeal of the claim.
- In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide the Plan participant with notice of the opportunity to resubmit and pursue the internal appeal of the claim.
- Time periods for re-filing the claim will begin to run upon the Plan participant's receipt of such notice.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

Under this Plan a non-network health care provider/facility is not a claimant that is permitted to start a lawsuit or other legal action to obtain Plan benefits. In addition, you are not required to exhaust external review before seeking judicial remedy. No lawsuit may be filed (started) more than three (3) years after the end of the year in which services were provided.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB)

HOW DUPLICATE COVERAGE OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. The COB provisions in this chapter pertain to the Medical Plans in this document, but the Plan does not coordinate benefits on outpatient prescription drug benefits.

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the Plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

When a plan participant is covered by more than one health plan (for example, when a spouse is covered under this group plan as well as under the spouse's own employer sponsored health plan), one plan is considered to be the primary payer and the other is considered to be the secondary payer. The primary payer covers the major portion of the bill according to that Plan's allowances, and the secondary payer covers some or all of the remaining allowable expenses. Other types of duplicate coverage include but are not limited to Medicare, Medicaid, motor vehicle insurance, or third party liability insurance.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this chapter). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

IMPORTANT INFORMATION ABOUT COORDINATION OF BENEFITS

Plan participants who are covered by more than one medical plan (called duplicate coverage) must let this Plan's Claims Administrators know about <u>all</u> the additional medical coverages they have.

Duplicate coverage includes, but is not limited to, another group plan, Medicare, Medicaid, Indian Health Services, motor vehicle insurance, or third party liability insurance.

Please contact the Claims Administrators listed on the Contact Information Chart in the front of this document to report any duplicate coverage.

Coordination of benefits (COB) is a process that determines financial responsibility for payment of covered expenses when an individual is covered by two or more group health plans. The objective of the Plan's COB process is to ensure that the group health plans combined will not pay more than 100% of covered expenses.

The County's COB activities will not interfere with a Member's medical care. Coordination of benefits is a bookkeeping activity that occurs between two medical plans or HMOs. However, a member may occasionally be asked to provide information about their other coverage.

The primary plan pays benefits first without regard to other coverage that may exist. A secondary plan pays after the primary plan. It typically takes into account what the primary plan paid so that payment from all applicable plans do not exceed 100% of the total covered expense.

The chart on the following page describes the rules for which plan is primary and which plan is secondary when there is the opportunity to perform coordination of benefits:

COORDINATION OF BENEFITS (COB) – NON-MEDICARE **If Rule 1 does not apply, go to the next until a rule applies.**
1. Subscriber vs Dependent. The plan covering the person as a subscriber (for example an employee or retiree) is primary, and the plan that covers the person as a dependent is secondary.
2. Plan without COB Provision. A Plan that does not contain a coordination of benefits provision is always primary.

COORDINATION OF BENEFITS (COB) – NON-MEDICARE

If Rule 1 does not apply, go to the next until a rule applies.

3. Child Covered by More Than One Plan. The order of payment when child is covered by more than one plan is as follows:

a) Birthday Rule (Parents with different Birthdays).
The primary plan is the plan of the parent whose birthday comes earliest in the year (not considered by year, considered by month/day) if:

- Parents are married;
- Parents are not separated;
- Court decree awards joint custody without specifying that one party has responsibility to provide health coverage.

b) Birthday Rule (Parents with same Birthdays). If the above applies but parents share the same birthday: The plan covering either of the parents longer is Primary.

c) Court-Ordered Responsible Parent. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan administrator of that parent has actual knowledge of those terms, that plan is primary.
This rule applies to claim determination periods or plan years starting after the plan administrator is given notice of the court decree.

d) Parents Not Married, Divorced, or Separated.
If there is no court order specifying responsibility for the child's health care coverage, this is the order of benefit responsibility:

- Plan of custodial parent;
- Plan of the spouse of the custodial parent;
- Plan of the noncustodial parent;
- Plan of the spouse of the noncustodial parent.

e) For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a spouse's plan, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent child or the employee-spouse covering the dependent child.

4. Active vs Inactive Employee.
When the person has the same status under both plans (i.e. person is the subscriber to both plans), the plan provided by active employment is first to pay; the plan that covers a person as an active employee is primary in relation to a plan that covers the person as a laid-off or retired employee.

5. Length of Coverage.
If the preceding rules do not determine the order of payment, the plan that has covered the individual longer is primary.

6. Equal Sharing.
If none of the preceding rules determines the primary plan, covered expenses will be shared equally between the plans.

Effect on the Benefits of This Plan

When the County's Medical Plan is secondary, it may reduce its benefits so that the total benefits paid are not more than 100% of total covered expenses. If a member is eligible for Medicare, please see the special note below concerning the coordination of benefits.

Coverage by Two Closed Panel Plans

The Kern Legacy Select Medical Plan, Kern Legacy Network Plus Medical Plan and the EPO Medical Plan are considered to be a closed panel plan because the Plan pays benefits (generally) only when health care services are provided by a network provider. If a covered person is enrolled in two or more closed panel plans and expenses are not covered by one closed panel plan, COB rules will not apply. But if services received from a non-network provider are due to an emergency and would be covered by both plans, then both plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

The County may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The County need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give the County any facts it needs to apply those rules and determine benefits payable.

The County's Right to Pay Others

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, the County may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. The County will not have to pay that amount again.

Recovery of Excessive Payments by the County

If the payment amount made by the County is more than it should have paid under this COB provision, the County may recover the excess from one or more of the persons it has paid, or for whom it has paid, or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the claims administrator may pay that amount to the organization that made the payment. That amount will then be treated as a benefit payable under this Plan, and the claims administrator will not have to pay that amount again. The term payment made can mean the reasonable cash value of the health care service provided**.**

Important Information for Medicare-Eligible Individuals

If a member (or their spouse) is eligible for coverage under Medicare while a Member in a County of Kern Medical Plan, the benefits payable under the Plan might be affected. An individual is considered eligible for Medicare if he or she is:

- Covered under (entitled to) Medicare, or
- Eligible but is not covered under Medicare because he or she refused, dropped or failed to make proper request for Medicare coverage.

In general, Medicare is the primary payer only for retirees age 65 and older. However, if a member reaches age 65 and they are still an active employee covered under a County medical plan and are eligible for Medicare, Medicare will be considered the secondary payer of benefits while the County's Medical Plan will be primary. Note that the County's Medical Plans will determine benefits payable to a Medicare-Eligible individual based on the assumption that such an individual has enrolled in Part B of Medicare. For more information, please contact the County Human Resources Division Health Benefits office.

Medicare is also the secondary payer for an:

- Active employee's spouse who is over the age of 65,
- Active employee's covered dependent who is eligible for Medicare due to a disability (regardless of age), or
- Individual receiving treatment for end-stage renal disease (during the first 30 months of such treatment).

COORDINATION OF BENEFITS (COB) – MEDICARE
Medicare Primary
1. Retiree Age 65 and older. This is generally the only time Medicare is Primary. This rule does not apply if the covered person is an Active employee. *See #2 if the covered person has Medicare but is not a retiree.*
Medicare Secondary
2. Employee: Active Employee over 65. When a person is an "Active Employee" with an "Active Employee" plan, Medicare is secondary.
Medicare Secondary
3. Spouse: Active Employee's spouse over 65. When a spouse is under the age of 65 is covered by a person who is an "Active Employee" with an "Active Employee" plan, Medicare is secondary.
4. Covered Dependent: Medicare Eligible Regardless of Age. When a dependent of an "Active Employee" is eligible for Medicare due to a disability (regardless of age) is covered by a person who is an "Active Employee" with an "Active Employee" plan, Medicare is secondary.
5. Person receiving treatment for End-Stage Renal Disease (first 30 months of treatment). When a person is receiving treatment for end-stage renal disease (during the first 30 months of such treatment), Medicare is secondary.
Medicare Primary
6. Person receiving treatment for End-Stage Renal Disease (after first 30 months of treatment). When a person is receiving treatment for end-stage renal disease after the first 30 months of such treatment, Medicare becomes primary.

Right of Reimbursement

This provision applies when a member or covered dependents receive or are eligible to receive reimbursement from a third party as the result of an illness or injury. This provision will apply whether or not the third party admits liability for payment. The purpose of this provision is to ensure that no benefit payments are duplicated under the Plan.

The term third party reimbursement includes any source of health care reimbursement. Examples: settlement, judgment, or uninsured/underinsured/no-fault motorist insurance coverage.

If third party reimbursement is or may be due to a member or covered dependents, but is not yet paid, the claims administrator may advance benefit payment to the individual. The individual must agree to:

- Promptly notify the claims administrator of any payment received from the third party, and
- Reimburse the claims administrator the benefits advanced under the Plan, up to the amount of any reimbursement received from the third party.

Any benefit paid will be subject to all provisions that apply under the Plan.

In the event a covered individual refuses to reimburse the claims administrator in accordance with the terms of this provision, the claims administrator has the right to deduct the amount of benefits paid from any future benefits payable to the covered individual or to any other covered family member. The claims administrator has the right to bring legal action against the covered individual to recover any balance owed under the terms of this provision.

Third Party Liability

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee** and/or a representative, guardian, conservator, or trustee of the Covered Individual, **and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);
5. even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as "contributory negligence") or any other common law defense.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. that the Plan has the first right of reimbursement from any judgment or settlement, including priority over any claim for non-medical charges, attorneys' fees or other costs and expenses; and
3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
4. to not assign the right of recovery to any third party without the specific consent of the Plan; and
5. to inform the Plan in writing if a covered Employee and/or covered Dependent(s) were injured by a third party and, within seven (7) days of such injury, provide information to the Plan Administrator; and
6. to notify and consult with the Plan Administrator or designee before initiating any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
7. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent(s) jointly agree that the Plan will be subrogated to the covered Employee and/or covered Dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any federal, state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.
2. Under its subrogation rights, the Plan may, at its discretion:
    a. initiate any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or

b. intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

1. The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:
   a. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
   b. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

F. Lien and Segregation of Recovery

By accepting the Advance, the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.
3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed. Such remedy shall be in addition to any other available remedies under the terms of the Health Plan and applicable law.

G. Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s); or
3. institute legal action to obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed. In such event, the covered Employee and/or covered Dependent(s) shall be liable for the amount Advanced as well as all of the Plan's costs of collection, including reasonable attorney fees and costs.

The Plan has six (6) years to seek reimbursement for all or part of an Advance received by a covered Employee and/or covered Dependent(s) because of any injury caused by a third party, and for which a covered Employee and/or Dependent or their counsel was awarded or received a monetary settlement from such injury from a court judgment, arbitration award, settlement or any other arrangement. The six-year timeframe begins from the date the Plan discovers that a covered Employee, covered Dependent(s) or their legal counsel was awarded or received such monetary recovery.

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan, for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov).

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

NOTE: Domestic Partners and children of Domestic Partners (as defined in this Plan) are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (described in this chapter); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This chapter describes in general how the Domestic Partner COBRA-like benefit will work. Contact the COBRA Administrator for questions.

COBRA Administrator: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Contact Information Chart in the front of this document.

IMPORTANT:
This chapter serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees, and is intended to inform them (and their covered Dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself.
It is important that you and your Spouse take the time to read this chapter carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage.

   - A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
   - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for health care coverage, or eligible but not at the same required premiums/contributions).	18 months	18 months	18 months
Employee dies.	Not applicable	36 months	36 months
Employee becomes divorced or legally separated.	Not applicable	36 months	36 months
Dependent Child ceases to have Dependent status.	Not applicable	Not applicable	36 months

[1]: *When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, **measured from the date of the loss of coverage following the Qualifying Event.** The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (making a total of 29 months) under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally, a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the Plan Administrator whose address is listed on the Contact Information Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Plan Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the employee's own employer should notify the Plan Administrator within 30 days of these events: an employee's death, termination of employment including retirement, reduction in hours making the employee ineligible for coverage, or entitlement to Medicare (if entitlement causes the employee to be ineligible for coverage). However, **you or your family should also promptly notify the Plan Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the employer providing that notification to the Plan Administrator.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the Plan Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Plan Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.** Under the law, you and/or your covered Dependents will then have only **60 days** from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

COBRA in Anticipation of a Divorce: If an employee eliminates coverage for his/her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a qualifying event even though the ex-spouse is not covered under the Plan on the date of the divorce. The COBRA regulations provide that if a covered employee eliminates or reduces a spouse's coverage **in anticipation of their divorce** or legal separation, then upon the Plan receiving a notice of the official divorce or legal separation, the Plan will offer COBRA to the ex-spouse as of the date of divorce or legal separation (even though the ex-spouse is not covered under the Plan at the time the divorce or legal separation is finalized).

The **ex-spouse must notify the Plan Administrator within 60 days from the date the divorce** or legal separation is final to trigger this Plan to take action on this situation (even if the divorce or legal separation decree or other court order requires the employee pay for the ex-spouse's health coverage). In accordance with approval by the Plan Administrator, the duration of COBRA is for a 36-month period measured from the date the divorce or legal separation is finalized.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

If you are participating in a **health flexible spending account (Health FSA)** at the time of the Qualifying Event, you will only be allowed to continue that Health FSA until the end of the current flex plan year in which the Qualifying Event occurred.

- Continuation of the Health FSA under COBRA is offered only when the employee's Health FSA is underspent when the qualifying event occurs (meaning that the underspent amount in the Health FSA exceeds the COBRA premium for that period).
- COBRA coverage is not offered to a Qualified Beneficiary who has exhausted their Health FSA, or whose Health FSA does not exceed the COBRA premium, at the time of the qualifying event.
- A Qualified Beneficiary's participation in the Health FSA will cease at the earlier of the end of the plan year in which the qualifying event occurs or if the COBRA premium payment is not made.
- When COBRA Continuation Coverage of your participation in the health care flexible spending account (Health FSA) is available, it will be on the same terms as for group health coverage, but since the person who elects COBRA will generally no longer be employed by their employer, it will not be possible to make contributions to the health care flexible spending account on a before-tax basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The County is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the County's and employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE:

- **While the Plan makes an effort to send invoices (payment reminders) for COBRA premium payments, you are still responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.**

Grace Periods

Initial COBRA Payment: The **initial payment** for the COBRA Continuation Coverage is due (in full) to the COBRA Administrator **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made in full and when due, COBRA Continuation Coverage will not take effect.

Subsequent COBRA Payments: After the initial COBRA payment, **subsequent COBRA premium payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those subsequent payments. For example, if the COBRA payment is due on July 1, the qualified beneficiary will have until July 30th to make the COBRA premium payment for July. Payment on or after July 31 is a late payment and COBRA coverage will be cancelled back to June 30th.

If the COBRA Administrator has not received your COBRA payment within the 30-day grace period indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date for the subsequent payment. Payment is considered made when it is postmarked.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

IMPORTANT REMINDERS

- ✓ **While the Plan makes an effort to send invoices (payment reminders) for COBRA premium payments, you are still responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.**
- ✓ **You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator in full and on time.**
- ✓ **If you fail to make a periodic COBRA premium payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.**

Confirmation of Coverage Before Election or Payment of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

HIPAA Special Enrollment and COBRA

- **Addition of Newly Acquired Dependents:** If, while you (a Qualified Beneficiary) are enrolled for COBRA Continuation Coverage (meaning timely elected and premium paid), you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 30 days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA. If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.
- **Loss of Other Group Health Plan Coverage:** If, while you (a Qualified Beneficiary) are enrolled for COBRA Continuation Coverage your Spouse or Dependent Child loses coverage under another group health plan, you may enroll the Spouse or Dependent Child for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent Child must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or Dependent Child must have been covered under another group health plan or had other health insurance coverage.

  The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent Child within 30 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

  Loss of coverage also includes a Dependent who loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). Enrollment in COBRA must be requested within 60 days after the Medicaid or CHIP coverage ends.

To request enrollment in COBRA for an eligible Dependent under Special Enrollment, the Qualified Beneficiary must, request enrollment within 30 days (60 days for CHIP) after the date on which the Dependent first becomes eligible for Special Enrollment, by contacting the COBRA Administrator and completing and submitting an enrollment form. Adding a Dependent may cause an increase in the amount you pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

*NOTE: Entitlement means the individual is eligible for and enrolled in Medicare. Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependent Children who are Qualified Beneficiaries. Legal separation is not a Qualifying Event under this Plan and as a result, legal separation following a termination of coverage or reduction in hours will not extend COBRA to 36 months for a Spouse and Dependent Child who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the COBRA Administrator in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of

COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

REMINDER: You must notify the Plan within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
   - the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
   - the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

   Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

REMINDER: You must notify the Plan within 60 days after receiving a disability determination letter from the Social Security Administration. Failure to notify the Plan in a timely fashion may jeopardize your rights to extended COBRA coverage.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the premium payment amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the the last day of the month prior to the month in which the Qualified Beneficiary is covered under the other group health plan.
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).
6. The date the County no longer provides group health coverage to any of its employees.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

a) Send a written request for an appeal to the COBRA Administrator within 60 days of the date you received the adverse determination letter.

b) Explain why you disagree with the adverse determination.

c) Provide any additional information you want considered during the appeal process.

d) Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this appeal within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Contact Information Chart in the front of this document.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Plan Administrator:

1. within 30 days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

GENERAL PROVISIONS

This section provides general information about the Plan including rights guaranteed to you under Federal law. For more information or assistance on benefits matters, contact the County Health Benefits Office (see the Contact Information Chart in the front of this document).

PLAN DOCUMENT GOVERNS

In all cases, this Plan Document controls the administration and operation of County of Kern self-funded Medical Plans.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Plan Administrator reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

NON-ASSIGNMENT

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their responsibilities, the Plan Sponsor, the Plan administrator, and the Plan fiduciaries have the full discretionary authority to interpret the terms of the Plan and to determine the eligibility for benefit payment in accordance with the terms of the Plan. Any interpretation or determination made by such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation was arbitrary and capricious. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

RIGHT OF PLAN TO REQUIRE A PHYSICAL EXAMINATION

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA), NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT), MENTAL HEALTH PARITY, AND MENTAL HEALTH PARITY ADDICTION EQUITY ACT REGULATIONS

This Plan complies with the Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act, Mental Health Parity, and Mental Health Parity Addiction Equity Act regulations. See the information described under Reconstructive services, Maternity services and Behavioral Health services in the Schedule of Medical Plan Benefits chart in this document.

MEDICAL MALPRACTICE DISPUTES

Any dispute alleging the medical malpractice, negligence and/or wrongful act of any health care provider shall not include the County of Kern or the Plan and shall include only the provider subject to the allegation.

NO GUARANTEE OF EMPLOYMENT

By adopting and maintaining this benefit Plan, the County of Kern has not entered into an employment contract with any employee. Nothing contained in the Plan document or in the description gives any employee the right to be employed by the County or to interfere with the County's right to discharge any employee at any time.

RECEIPT OF DOCUMENTS

Any written notice, acknowledgement, request, decision, or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed", means the person's last known address.

PLAN FUTURE

The Plan Sponsor reserves the sole right and authority to terminate, suspend, withdraw, amend or modify the Plan at any time.

HEADINGS, FONT AND STYLE DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the **convenience** of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the County of Kern self-funded health benefits (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by the County of Kern in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the County of Kern Human Resources Division. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the County Board of Supervisors), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

     c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including Prior Authorization, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available from the County of Kern Human Resources Division) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

  1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

  2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

  3. Not use or disclose the information for employment-related actions and decisions;

  4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

  5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

  6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

  7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

  8. Make available the information required to provide an accounting of PHI disclosures;

  9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

  10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

  11. Notify you if a breach of your unsecured protected health information (PHI) occurs.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

  1. County of Kern Human Resources Division staff who administer the self-funded health benefits.

2. Business Associates under contract to the Plan including but not limited to the medical plan claims administrators, medical plan networks, utilization management companies, outpatient prescription drug program administrator, Health FSA administrator, HSA administrator, and COBRA administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (whose address and phone number are listed on the Contact Information Chart in the front of this document).

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a self-funded health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options with outpatient prescription drug benefits, COBRA administration and Health Flexible Spending Account (FSA) administration.

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The County of Kern complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The County of Kern does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The County of Kern:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the County of Kern Civil Rights Coordinator). If you believe that the County of Kern has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

County of Kern Civil Rights Coordinator
Attn: Chief Human Resources Officer
1115 Truxtun Ave, 1st Floor
Bakersfield, CA 93301
Phone: 661-868-3182
Fax: 661-868-3110

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the County of Kern Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of California:

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-661-868-3280 or 1-855-308-5547.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-661-868-3280 or 1-855-308-5547.
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-661-868-3280 or 1-855-308-5547.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-661-868-3280 or 1-855-308-5547.
Persian (Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با1-661-868-3280 or 1-855-308-5547 تماس بگیرید.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-661-868-3280 or 1-855-308-5547 पर कॉल कर।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-661-868-3280 or 1-855-308-5547.
Arabic	(مقر (661) 868-3280 or 1 (855) 308-5547 لصتا مقرب ناجملاب. ةيوغللا نافِ تامدخ ةدعاسملا رفاوتت كل ،ةغللا نافِ تامدخ ركذا تنك ثدحتت فتاه مصلا مكبلاو1-661-868-3280 or 1-855-308-5547 ةظوحلم: اذإ
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-661-868-3280 or 1-855-308-5547 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-661-868-3280 or 1-855-308-5547.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 1-661-868-3280 or 1-855-308-5547.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-661-868-3280 or 1-855-308-5547 まで、お電話にてご連絡ください。
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-661-868-3280 or 1-855-308-5547.
Cambodian	□□□□□□□□ □□□□□□□□□□□□□□□ □□□□, □□□□□□□□□□□□□□ □□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□ □□□ □□□□□□□1-661-868-3280 or 1-855-308-5547□
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-661-868-3280 or 1-855-308-5547 'ਤੇ ਕਾਲ ਕਰੋ।

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration and claim appeals are found in the Claim Filing and Appeals Information chapter of this document.

Accident and Accidental means an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Adverse Benefit Determination: See the Claim Filing and Appeal Information chapter for the definition.

Affordable Care Act (ACA): a comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, Health Reform, or "Obamacare"). The law has two parts: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (the Reconciliation Act). The Affordable Care Act includes requirements for coverage of certain health care services that impact medical plans including the County's medical plan options.

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee for the Medical Plan(s): means the amount this Plan allows as payment for eligible medically necessary covered services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee(s) to be the **lowest** of:

1. **With respect to a network provider**, Allowed Charge amount means the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the network or the Plan; **or**
2. **With respect to a Non-Network provider**, for the Kern Legacy Select Plan and the Kern Network Plus Plan, Allowed Charge amount means the amount the Plan has negotiated with the non-network provider for eligible medically necessary covered services or supplies performed by Non-Network providers. For the POS Plan and the EPO Plan Allowed charge means the schedule that lists the dollar amounts the Plan has determined it will allow for use of a non-network provider; or
3. For a network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a network claim; **or**
4. The **negotiated discounted amount that a non-network provider agreed to**, reducing the provider's original billed charges to a lower, discounted amount; **or**
5. The Health Care or Dental Care Provider's/facility's **actual billed charge**.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

The Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, Network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

In accordance with federal law, with respect to emergency services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees and ER professional fees is to pay the **greater** of:

a) the negotiated amount for Network providers (the median amount if more than 1 amount to Network providers), or
b) 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
c) (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

NOTE: Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use a non-network provider you may be balance billed by that provider, except for emergency services performed in an emergency room. These minimum payment standards for emergency services in a hospital emergency room do not apply in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges. See also the definition of Balance Billing in this chapter.

Ambulance, Professional Ambulance Service: means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is

a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless and in need of immediate medical transportation; or
d) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical transportation services include transportation of individuals who cannot use public or private transportation because of their Medically Necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical transportation services are payable by this Plan when those expenses have been pre-approved by the UM Company or Medical Plan Claims Administrator. See the Schedule of Medical Benefits chapter in this document.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures (and does not provide for overnight stays) and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
   - requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   - provides at least one operating room and at least one post-anesthesia recovery room.
   - is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
   - has trained personnel and necessary equipment to handle emergency situations.
   - has immediate access to a blood bank or blood supplies.
   - provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
   - maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

Ambulatory Surgical Facility/Center is sometimes called an Outpatient Surgicenter or Outpatient Surgical Facility.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. In essence, systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the Physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a. the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant (PA), Registered Nurse First Assistant (RNFA) but not an employee of a hospital or surgical facility or a medical student, intern, or other trainee; and
b. the use of an assistant surgeon(s) is determined by the Plan Administrator or its designee to be Medically Necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's annual Out-of-Pocket Limit is reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's annual Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing**. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the plan's payment for a covered service. Generally, you can avoid balance billing by using Network providers for covered services. Typically, Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using Network providers.**

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or substance abuse/substance use disorder. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center.
   - is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - provides at least two beds or two birthing rooms.
   - is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - has trained personnel and necessary equipment to handle emergency situations.
   - has immediate access to a blood bank or blood supplies.
   - has the capacity to administer local anesthetic and to perform minor Surgery.
   - maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
   - is expected to discharge or transfer patients within 48 hours following delivery; and
   - is accredited by the American Association of Birth Centers (AABC).

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical Plans, all annual Deductibles, Out-of-Pocket Limits and Annual Maximum Plan benefits are determined during the calendar year.

Chemical Dependency: See Substance Abuse.

Child(ren): See the definition of Dependent Child(ren) and children of Domestic Partner.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Claim, Claimant: See the Claim Filing and Appeal Information chapter for the definition.

Claims Administrator: The independent companies retained by the County to administer the medical and outpatient prescription drug claims including claim processing, appeals and payment responsibilities and other administration or accounting services as specified by the Plan. The contact information for the various Claims Administrators are listed on the Contact Information Chart in the front of this document.

Coinsurance: is a percentage of eligible expenses for which members are responsible.

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur a covered medical expense for certain services.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Cost-sharing: A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary).

Covered Charge means any expense that is eligible for benefits and not otherwise excluded under this Plan.

Covered Individual: An eligible employee and that person's eligible Spouse or Dependent Child, or Domestic Partner, or child of a Domestic Partner, who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A covered individual is also referred to as a Plan Participant.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by individuals who are not trained or licensed medical or nursing personnel.

Deductible: The amount of covered medical expenses you are responsible for paying before the Plan begins to pay benefits.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are not covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise in this document.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse, or Domestic Partner or child of a Domestic Partner as those terms are defined in the County's Eligibility document.

Durable Medical Equipment (DME): Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable, is for the exclusive use of the patient, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, ventilators and necessary mobility devices like walkers/crutches.

Elective: Services/procedures that can be scheduled/performed at varying times without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren), Domestic Partner, or Domestic Partner's child.

Eligible (Covered) Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are an Allowed Charge, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded; and the Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan. An expense is incurred on the date the service or supply is received.

Emergency Care, Emergency: A service or supply is or should be classified as Emergency Care. Emergency care means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a **prudent layperson** who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).
- The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Employer is the County of Kern (located in California) or qualified Special Districts.

Experimental and/or Investigational or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Prior Authorization under the Plan's Utilization Management program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

Note that under the medical plans described in this document, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, <u>prior authorization is required</u> in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the Plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The Plan may require that an eligible individual use a Network provider as long as the provider will accept the patient. This Plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

e. The Plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for prior authorization under the Plan's Utilization Management program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S. such as Aetna, Anthem, CIGNA, Unitedhealthcare, MCG Care Guidelines, formerly Milliman Care Guidelines, the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines or, the American Dental Association (ADA) with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain Prior Authorization of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, see the Prior Authorization chapter in this document.

Family means a Participant and his eligible Dependents. Under any benefit section, a "covered family member," is a family member for whom coverage is then in force.

FDA approved contraceptives: include permanent sterilization, long-acting contraceptives, contraceptive injections, short-acting hormonal methods, barrier methods, and emergency contraception. For more information see this website: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm.

Formulary: A list of outpatient prescription drug products, including strength and dosages, approved by the Prescription Drug Program, and available for use by Plan participants. The formulary approval process considers factors such as drug safety, effectiveness, cost-effectiveness, side effects and therapeutic outcome. A formulary is also called a Preferred drug list. The Prescription Drug Program makes changes to the formulary, considering new information that is available and new FDA approved drug announcements.

- **Formulary Includes Three-Tier Prescription Drug Benefits:** You cost-sharing for a covered outpatient drug is determined by the Medical Plan in which you are enrolled and the drug tier in which your medication applies. No matter which Tier your prescription is under, your copayment represents a significant savings to you compared to the medication's full retail cost.
    1. **Tier 1** includes all covered **generic medications**, which are the Plan's preferred agents or first line therapy choice. Generic drugs are chemically identical to brand name drugs but are priced at a fraction of the cost of the corresponding brand name drug. The U.S. Food and Drug Administration (FDA) requires that generic drugs provide the same effectiveness and safety as their brand name counterparts. The FDA requires drug manufacturers to show that the generic version enters the bloodstream the same way, contains the same amount of active ingredient, comes in the same dosage form and is taken the same way as the brand name drug. You pay the lowest copayment for generic medications.
    2. **Tier 2** includes **preferred brand name medications** that are still patent protected and do not have generic alternatives available. The Prescription Drug Program's Pharmacy and Therapeutics (P&T) Committee has reviewed these medications and found that they are therapeutically superior, offer a better outcome, have a better safety profile, or provide the same therapeutic effect as comparable drugs in Tier 3, but Tier 2 drugs will save the Plan money. You pay the middle copayment for preferred brand name medications.
    3. **Tier 3** includes **non-preferred brand name medications**, drugs that either have equally effective and less costly generic equivalents or one or more alternative preferred brand name medications available in Tier 2 that provide the same therapeutic effect. You or your doctor may decide that a medication in this category is best for you. If you choose a Tier 3 drug, your contribution to the cost of the medication may be the highest copayment.
- The fact that your physician prescribes a particular drug or medication does not automatically mean that it will be covered under the Plan. If the prescribed drug or medication does not have a generic form or is not on the Plan's formulary, the network pharmacist will consult with your doctor to determine the best equivalent for you. The Plan Administrator or its designee may, on review, provide payment for non-formulary drugs when medically necessary.
- **Off-label Use of Medication** - Prior authorizations for unlabeled uses of medications may be granted by the Plan if: a) the medication is a cancer treatment drug approved by the FDA; and b) two or more peer-reviewed professional medical journals have recognized, based on scientific medical criteria, the safety and effectiveness of the medication or combination of medications, for treatment of the indication for which the medication has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or the safety and ineffectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Facility: For the purposes of this Plan, a facility for the delivery of health care services including an Outpatient Ambulatory Surgical Facility/Center, Hospital, Behavioral Health Treatment Facility, Birthing Center, Inpatient Hospice Facility, Residential Treatment Facilities, Inpatient Rehabilitation Facility, Skilled Nursing Facility, and Subacute Care Facility/Long Term Acute Care (LTAC) facility, Urgent Care Facility all of whom are legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where the services are rendered. Many of these facility terms are separately defined in this chapter.

Health Care Practitioner: Behavioral Health Practitioner (including licensed psychologist (PhD), clinical specialist psychiatric registered nurse (CSPRN), mental health or substance abuse counselor or social worker who has a Master's degree), licensed clinical social worker, certified registered nurse anesthetist(CRNA), Chiropractor, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Certified Nurse Midwife, Physician Assistant (PA), or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Registered Dietitian, Certified Diabetes Educator, or Pharmacist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility/Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
   - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
   - has a full-time administrator.
   - is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
   - maintains written clinical records of services provided to all patients.
   - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
   - its employees are bonded.
   - maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. "Palliative care" refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms along with psychological, social and spiritual support. Many hospice organizations are members of the National Hospice and Palliative Care Organization (NHPCO).

The hospice agency must meet one of the following tests:

1. It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
   - provides 24 hour-a-day, 7 day-a-week service.
   - is under the direct supervision of a duly qualified Physician.
   - has a full-time administrator.
   - has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
   - the main purpose of the agency is to provide Hospice services.
   - maintains written records of services provided to the patient.
   - maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

1. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and
2. provides diagnosis and treatment on an inpatient basis for compensation; and
3. is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include inpatient acute care facilities for Behavioral Health treatment or for Inpatient Rehabilitation that are licensed and operated according to law.

Hospitalist: means a physician whose primary professional focus is the general medical care of hospitalized patients. Hospitalist activities include patient care, teaching, research, and leadership related to hospital medicine. The hospitalist is under contract to a hospital or health care facility to provide care to patients admitted to that facility.

Illness: Any bodily sickness or disease, including any congenital abnormality of an eligible newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable (see the Schedule of Medical Benefits chapter in this document.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Intensive Outpatient Program (IOP): means providing treatment in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week (e.g. counseling provided at least 2-4 hours/day or evening, and held 3-7 times a week). Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day. The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient hospital admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60 minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health provider's office for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

Investigational: See the definition of Experimental and/or Investigational.

Kern Medical: is a Central Valley California public health care organization that includes a trauma/teaching hospital along with primary care and specialist clinics. Kern Medical contracts with the County of Kern to provide health care for the County's medical plan participants.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Medically Necessary/Medical Necessity:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
   3. is determined by the Plan Administrator or its designee to meet <u>all</u> of the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
      - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

H. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort, convenience or preference of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Health; Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Morbid Obesity: is a disorder involving excessive body fat. For this Plan, morbid obesity means an individual who has a BMI of 40 or more, or a BMI of 35 or more and who is experiencing clinically significant obesity-related health conditions, such as obstructive sleep apnea, coronary heart disease, medically refractory high blood pressure or Type 2 diabetes. BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared. BMI can be calculated using the National Heart, Lung and Blood Institute website: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm and https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_dis.htm.

Network/Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Network or Pharmacy Benefit Manager, as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Network or Pharmacy Benefit Manager.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc.

Non-Network, Non-Participating Provider: A Health Care Provider who **does not participate** in one of the Plan's Preferred Provider Networks. A retail pharmacy that does not contract with the Plan's selected Pharmacy Benefit Manager. Non-participating is also referred to as Out-of-Network or Non-Network.

Off-Label: Off-label prescription drugs are FDA-approved prescription drugs that are prescribed for indications other than those stated in the labeling approved by the FDA.

Open Enrollment Period: The period during which an employee may add coverages of dependents, drop coverages or dependents or select among the alternate health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is described in the County's Eligibility document.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or Temporomandibular Joint syndrome/dysfunction.

Out-of-Network: see Non-Network.

Out-of-Pocket Limit: The Out-of-Pocket Limit is the most a plan participant will pay each calendar year for deductibles, coinsurance and copayments for essential health benefits related to covered Medical plan and outpatient prescription drug benefits from in-network providers before their Medical plan starts to pay 100% for covered essential health benefits.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

Partial Day Care/ Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse at a hospital (on an outpatient basis) for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a hospital/facility. Partial day care is active treatment that incorporates individualized treatment plans that describe the type, frequency, and duration of services as well as coordination of services around each patient's needs. The services must require a multidisciplinary team approach under the direction of a physician and reflect structure and scheduling. Treatment goals should be measurable, functional, regularly scheduled, medically necessary, and directly related to the partial day care program. Patients must be under care of a physician who certifies the medical necessity of the services. Patient must be able to participate and tolerate a minimum of 20 hours per week of therapeutic services. The services must be comprehensive, structured, multimodal treatment that necessitates medical supervision and coordination due to a mental disorder (i.e., mental health diagnosis) that severely interferes with daily life. Partial day care should include: individual or group psychotherapy, family counseling services, patient training and education and medically necessary diagnostic services related to mental health and/or substance abuse treatment.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license. See also the definition of Health Care Practitioner.

Plan, This Plan: The programs, benefits and provisions described in this document, and as formally amended.

Plan Administrator/Plan Sponsor: The County of Kern who has been designated as the Plan Administrator and who has the responsibility for overall Plan administration. For contact information and daily plan administration duties, see the County of Kern, County Administrative Office - Human Resources Division.

Plan Participant: See the definition of Covered Individual.

Plan Sponsor: Is the same meaning as the Plan Administrator.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug/Compounding:** Any drug that has more than one ingredient and at least one ingredient is a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug**: Refers to high-cost, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling, distribution and administration issues. Examples of specialty drugs can include medications (and the supplies necessary to administer them) to treat hemophilia, multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, hepatitis, cancer or immunity disorders.

Preventive services/Preventive Care Benefits: are defined under the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control & Prevention (CDC), and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration (HRSA).

Primary Care Physician (PCP): means the following physicians: family practitioners, general practitioners, internists, OB/GYNs, and pediatricians.

Prior Authorization/Prior Auth: is a review procedure performed by the County's contracted Utilization Management Company or the Pharmacy Benefit Manager **before** services are rendered, to assure that health care services including certain drugs meet or exceed accepted standards of care and that the drugs, service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary. Prior authorization is also referred to as precertification, precert, pre-service review, preauthorization, pre-admission review, prior approval or preapproval.

Provider: See the definition of Health Care Provider and Health Care Practitioner.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital birth defect/anomaly, or covered surgery. Breast reconstruction following a total or partial mastectomy is a covered reconstructive surgery.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on therapy to help an individual attain certain functions that have never have acquired, such as speech therapy to assist a child in learning to talk. See also the definition of Habilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Residential Treatment Program/Facility/Care: is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state) and contracted as a Network provider.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to individuals who require medical or nursing care and that rehabilitates injured, disabled or sick individuals, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care (non-skilled/custodial care, assisted living care facility, memory care/dementia care facility), or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or mentally ill; and
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Special District: a County of Kern approved special district agency operating within the County of Kern.

Specialist: a Physician or Health Care Practitioner that is not a Primary Care Physician (PCP).

Specialty Drugs: See Prescription Drugs.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is performed by a Chiropractor or Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Spouse: An employee's Spouse means a person of the opposite gender or same gender who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union partner, or a divorced former Spouse of an employee, a common law marriage, or a spouse of a Dependent Child. An ex-spouse is not eligible even if an employee is required by a divorce decree, court order or other legal action to continue coverage for the ex-spouse.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the section on Third Party Liability in the Coordination of Benefits chapter in this document has an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated

with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Third Party Liability means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the medical care expenses resulting from bodily injury and/or material damage caused to a plan participant as a result of the action or inaction, or negligence of a third party. See also Subrogation.

Total Disability: as it applies to an Employee means the Employee is unable, as a result of Sickness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit. As it applies to a Dependent, it means that the Dependent, as a result of Sickness or Injury, is unable to perform the normal duties appropriate to a person in good health of the same sex and age.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

See the Schedule of Medical Benefits and the Exclusions chapter for additional information regarding Transplants. See also the Prior Authorization chapter of this document for information about prior authorization requirements for transplantation services.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, or during or after the services are rendered services being rendered, and may include, but is not limited to Prior authorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review (such as with a post-service claim); Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the County.

Utilization Management Company/UM Company: The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Management services.