



# County of Kern Point of Service (POS) Plan

## Summary of Member Benefits and Co-pays – Active Employees

Type of Plan/Benefit Level	Point of Service (POS) Plan	
	POS In-Network	Out-of-Network
<b>Who Directs Your Care</b>	<b>Member</b> (some services require member to obtain prior authorization)	
<b>Who Provides Your Care</b>	Providers contracted with this plan. Specialist visits require a referral or a Prior Authorization. Prior authorization must be obtained for services not available in the network.	Any licensed provider rendering covered services when referral/authorization was not obtained for In-Network benefits. When providers who are contracted on the national network are used as out-of-network providers, their fee discount reduces your out-of-pocket expenses.
<b>Annual Deductible</b>	\$0	\$200 per individual \$400 per family (2 mbrs @ \$200)
<b>Calendar Year Out-of-Pocket Max</b> (Once this maximum is paid by the member, the plan pays a higher amount - up to 100% coverage)	Medical: \$1,000/person; \$3,000/family Pharmacy: \$5,600/person; \$10,200/family	\$2,000 per person \$4,000 per family (2 mbrs @ \$2,000)
<b>Primary Physician Visit</b>	\$15 copay	70% coverage R&C <sup>1</sup>
<b>Specialist Physician Visits</b>	\$25 copay	70% coverage R&C <sup>1</sup>
<b>Well Baby Care (up to age 2)</b>	\$15 copay	70% coverage R&C <sup>1</sup>
<b>Adult Periodic Health Evaluations <sup>2</sup></b>	\$15 copay	Not covered
<b>Outpatient Surgery / Procedure</b>	\$0 copay at KMC or \$100 copay	70% coverage R&C <sup>1</sup>
<b>Inpatient Hospitalization</b>	\$0 copay at KMC or \$150 copay per day, up to \$750 yr max	70% coverage R&C <sup>1</sup>
<b>Emergency Room</b>	\$75 copay (waived if admitted)	
<b>Urgent Care</b>	\$15 copay	70% coverage R&C <sup>1</sup>
<b>Mammogram &amp; Pap Smear</b>	\$0 copay	Not Covered
<b>Immunizations</b> (office visit co-pay may apply)	\$0 copay	70% coverage R&C <sup>1</sup>
<b>Diagnostic Lab/X-Ray</b>	\$0 copay	70% coverage R&C <sup>1</sup>
<b>Physical, speech and occupational therapy</b>	\$0 copay (max 60 visits/year combined)	70% coverage R&C <sup>1</sup> (max. 60 visits/yr combined)
<b>Durable Medical Equipment</b>	\$0 copay	70% coverage R&C <sup>1</sup>
<b>Allergy Testing &amp; Diagnosis</b>	\$0 copay	70% coverage R&C <sup>1</sup>
<b>Chiropractic</b>	\$20 maximum benefit/visit – max. 30 visits per yr	
<b>Prescription - Retail</b>	30 day at contracted pharmacy: \$5 Generic (\$0 at KMC Pharmacies) <sup>3</sup> \$15 Preferred Name brand \$30 Non-Preferred Name brand	
<b>Prescription - Mail order</b>	90 day through WellDyne Home Delivery: \$10 Generic \$30 Preferred Name brand <sup>3</sup> \$60 Non-Preferred Name brand <sup>3</sup>	

(1) After deductible has been met.

(2) Over 2 years old.

(3) If no generic available. Higher cost if generic is available.

**Please Note:** This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, out-of pocket maximums, exclusions or limitations, nor does it list all benefits. For a complete explanation, please refer to the Summary Plan Description.