County of Kern Point of Service (POS) Plan

Summary of Member Benefits and Co-pays – Retirees

Type of Plan/Benefit Level	Point of Service (POS) Plan	
	POS In-Network	**Out-of-Network**
Who Directs Your Care	**Member** (some services require member to obtain prior authorization)	
Who Provides Your Care	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.
Annual Deductible	$0	$200 per individual $400 per family(2 mbrs @ $200)
Calendar Year Out-of-Pocket Max (Once this maximum is paid by the member, the plan pays a higher amount - up to 100% coverage)	n/a: copay always applies	$2,000 per person $4,000 per family (2 mbrs @ $2,000)
Primary Physician Visit	$15 copay	70% coverage R&C [1]
Specialist Physician Visits	$25 copay	70% coverage R&C [1]
Well Baby Care (up to age 2)	$15 copay	70% coverage R&C [1]
Adult Periodic Health Evaluations [2]	$15 copay	Not covered
Outpatient Surgery / Procedure	$0 copay at KMC or $100 copay	70% coverage R&C [1]
Inpatient Hospitalization	$0 copay at KMC or $150 copay per day, up to $750 yr max	70% coverage R&C [1]
Emergency Room	$75 copay (waived if admitted)	
Urgent Care	$15 copay	70% coverage R&C [1]
Mammogram & Pap Smear	$0 copay	Not Covered
Immunizations (office visit co-pay may apply)	$0 copay	70% coverage R&C [1]
Diagnostic Lab/X -Ray	$0 copay	70% coverage R&C [1]
Physical, speech and occupational therapy	$0 copay (max 60 visits/year combined)	70% coverage R&C [1] (max. 60 visits/yr combined)
Durable Medical Equipment	$0 copay	70% coverage R&C [1]
Allergy Testing & Diagnosis	$0 copay	70% coverage R&C [1]
Chiropractic	$20 maximum benefit/visit – max. 30 visits per yr	
Prescription - Retail	30 day at contracted pharmacy: $5 Generic ($0 at KMC Pharmacies) [3] $25 Preferred Name brand $40 Non-Preferred Name brand	
Prescription - Mail order	90 day through WellDyne Home Delivery: $10 Generic $30 Preferred Name brand [3] $60 Non-Preferred Name brand [3]	

(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.