Sharewell Retiree PPO Health Plan - 2023

blue of california

Family Deductible (Calendar Year) The Family Deductible must be satisfied before most covered Medical and Pharmacy expenses are reimbursed by the Plan.	$5,000 (combined Network and Non-Network) All covered Medical and Pharmacy Expenses accumulate toward both the Network and Non-network Deductible
Out-of-Pocket Maximum Benefit (Calendar Year) After all out-of-pocket expenses for incurred covered services (including deductibles and coinsurance) have totaled the amount shown, the PLAN will pay 100%.	Network: $6,000 Family Non-Network: $12,000 Family ***EXCLUSIONS**: Costs of medical and pharmacy services not covered; Non-Network amounts in excess of the Usual, Reasonable and Customary (URC) amount; and 20% co-insurance for failure to obtain pre-admission review for non-emergency hospitalization. See additional considerations and exclusions listed below for prescription drugs.
The Covered Person pays the following percentage of Covered Medical and Pharmacy expenses after the annual Calendar Year Family Deductible has been satisfied (except as noted below) **The non-network coinsurance is based on the URC for that service and the member is responsible for any balance billed.*	
Preventive Care Services and Drugs As set forth in Plan Document	No co-insurance and no deductible
Primary Care and Specialist Physician Office Visits, Laboratory and Radiology Services, Urgent Care Facility, Rehabilitative Therapy, and Outpatient Surgery-Hospital	Network: 10% co-insurance Non-Network: 30% co-insurance
Medical - Inpatient Hospital Services	Network: 10% co-insurance Non-Network: 30% co-insurance; without pre-admission review, 50% co-insurance
Outpatient Surgery - Ambulatory Surgery Center (facility charges)	Network: 10% co-insurance Non-Network: Plan pays 70% up to $1,500/ day; participant responsible for balance
Emergency Room Treatment Based on Plan Document "Emergency Services" definition	Medical condition ***does*** meet definition Network/Non-Network: 10% co-insurance Medical condition ***does NOT*** meet definition Network: 10% co-insurance Non-Network: 10% co-insurance *Non-Network - covered person is responsible for all charges incurred above the URC amount.
Mental Health and Substance Abuse - Inpatient and Outpatient Services	Network: 10% co-insurance Non-Network: 30% co-insurance; without pre-admission review for inpatient, 50% co-insurance
Chiropractic or Acupuncture Services Calendar year maximum of 25 visits for acupuncture services and 25 visits for chiropractic services (combined Network/Non-Network)	Network: 10% co-insurance Non-Network: 30% co-insurance

Outpatient Radiological/Nuclear Imaging and Spine Surgery/Pain Management Procedures (Non-Emergency) Prior authorization required for non-emergency outpatient: - Radiological/Nuclear Imaging (such as CT/PET scans, MRIs) - within California - Spine Surgery/Pain Management - within United States	Network: 10% co-insurance Non-Network 30% co-insurance
Durable Medical Equipment Prior authorization required if over $5,000	Network: 10% co-insurance Non-Network: 30% co-insurance
Dialysis Services (Outpatient)	Network: 10% co-insurance Non-Network (within CA): Plan pays 70% up to $600/day; participant pays balance Non-Network (outside CA): 30% co-insurance
Home Health Care and Hospice Services Requires prior authorization	Network: 10% co-insurance Non-Network: 30% co-insurance
Skilled Nursing and Rehabilitation Facility 100 days per Calendar Year limit	Network: 10% co-insurance Non-Network: 30% co-insurance
Telemedicine Visit: 1-800-TELADOC Access to board-certified doctors 24/7/365 who are ready to treat many non-emergency medical issues(including mental health services) at a lower cost than an office visit or urgent care. With Teladoc's convenient phone and online video appointments, you can save a trip to the doctor's office. Teladoc is an in-network service.	Once you have met your deductible, you pay the 10% co-insurance.
Prescription Drugs Coverage Prescription drugs are subject to the plan deductible. The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available.	20% co-insurance *IMPORTANT CONSIDERATIONS: If member chooses a brand name drug when a generic equivalent is available, member will pay 20% of generic cost plus the cost differential between generic and brand name cost. The cost differential does not accumulate towards the out-of-pocket maximum. All Specialty Drugs must be fulfilled by OptumRx Specialty Pharmacy in order to be covered. Manufacturer specialty coupon cards do not count towards the annual deductible or out-of-pocket maximum. Medication not covered by the plan and filled through Optum's enhanced savings program will not count towards the annual deductible or out-of-pocket maximum.

This is only a summary of benefits. This chart contains the major features of the plan and is not intended to replace the Plan Document containing the complete provisions.

Helpful Contact Information

Blue Shield of California	OptumRx
Current and Prospective Sharewell and Wellwise Members: 1-888-235-1767 www.blueshieldca.com/oc	***Current Members:*** 1-800-573-3583 www.optumrx.com ***Prospective Members:*** 1-844-880-0759 https://www.optumrx.com/oe_countyoforange/landing ***Optum Specialty Pharmacy:*** 1-855-427-4682 specialty.optumrx.com

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California 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:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Din4 k'ehj7 doo b22h 7l7n7g0 sh7ka' at'oowo[n7n7zingo, kwij8' hod77lnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): اگر برای دریافت کمک رایگان به زبان فارسی، با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ

Khmer (ភាសាខ្មែរ): សូមទូរស័ព្ទមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية، اتصل على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बोलने के सहायता के लिए, 1-866-346-7198

पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198