

# Wellwise Non-Medicare Retiree PPO Health Plan - 2023



blue  of california

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| <b>Deductible (Calendar Year)</b><br>Each Covered Person must satisfy the Annual Calendar Year Deductible before most Covered Medical Expenses are reimbursed by the PLAN.   | Network: \$500 Individual/\$1,000 Family<br>Non-Network: \$750 Individual/\$1,500 Family   |
| <b>Out-of-Pocket Medical Maximum Benefit (Calendar Year)</b><br>After all out-of-pocket medical expenses for incurred covered services (including deductibles and coinsurance) by a Covered Person have totaled the amount shown, the PLAN will pay 100%.  | Network: \$2,500 Individual/\$5,000 Family<br>Non-Network: \$5,000 Individual/\$10,000 Family<br><br><b>*EXCLUSIONS:</b> Pharmacy expenses; Costs of services not covered; Non-Network amounts in excess of URC (balance billing); and 20% co-insurance for failure to obtain pre-admission review for non-emergency hospitalization.  |
| <b>Prescription Drug Card Program through OptumRx</b><br><br><ul style="list-style-type: none"> <li>– Preventive Drugs – as set forth in the Plan Document</li> <li>– Tier 1 - Mostly Generic Drugs</li> <li>– Tier 2 - Preferred – Mostly Brand Name Drugs<sup>1</sup></li> <li>– Tier 3 - Non-Preferred – Mostly Brand-Name<sup>1</sup></li> <li>– Specialty Drugs<sup>1</sup></li> </ul> Preauthorization is required for select drugs<br><br><u>Drug Exclusions:</u> The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available. | No Calendar Year Deductible<br><br><ul style="list-style-type: none"> <li>– Preventive Drugs = 0% co-insurance</li> <li>– Tier 1 = 20% co-insurance</li> <li>– Tier 2 = 25% co-insurance<sup>1</sup></li> <li>– Tier 3 = 30% co-insurance<sup>1</sup></li> <li>– Specialty Drugs = Percentage indicated for each tier above<sup>1</sup>, up to a maximum of \$150 per 30-day supply</li> </ul> Out-of-Pocket Prescription Drug Maximum Benefit<br>\$4,100 Individual/\$8,200 Family (Calendar Year)<br><br><sup>1</sup> 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.<br><br><b>Not included in the prescription drug out-of-pocket limit:</b> Drugs not covered by the plan; Drugs filled through Optum's enhanced savings program; and the cost differential between generic and brand drug if member chooses brand drug when a generic equivalent is available. |
| <b>The Covered Person pays the following percentage of Covered Medical expenses after the Covered Person's Annual Calendar Year Deductible has been satisfied (except as noted below)</b>  |  |
| <b>Preventive Care Services</b> As set forth in Plan Document  | No co-insurance and no deductible  |
| <b>Primary Care and Specialist Physician Office Visits, Laboratory and Radiology Services, Urgent Care Facility, Rehabilitative Therapy, and Outpatient Surgery - Hospital</b>   | Network: 10% co-insurance<br>Non-Network: 10% co-insurance   |
| <b>Medical - Inpatient Hospital Services</b>   | Network: 10% co-insurance<br>Non-Network: 30% co-insurance; without pre-admission review, 50% coinsurance  |
| <b>Outpatient Surgery - Ambulatory Surgery Center (facility charges)</b>   | Network: 10% co-insurance<br>Non-Network: Plan pays 70% up to \$1,500/day; participant pays balance  |

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| <b>Emergency Room Treatment</b><br>Based on Plan Document "Emergency Services" definition   | For a Non-Participating Provider who provides Emergency Services anywhere: Physicians and Hospitals: the amount is the Reasonable and Customary amount; or All other providers: (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under federal law. |
| <b>Mental Health and Substance Abuse - Inpatient and Outpatient Services</b>  | Network: 10% co-insurance<br>Non-Network: 30% co-insurance; without pre-admission review for inpatient, 50% co-insurance   |
| <b>Chiropractic or Acupuncture Services</b><br>Calendar year maximum of 25 visits for acupuncture services and 25 visits for chiropractic services (combined Network/Non-Network)   | Network: 10% co-insurance<br>Non-Network: 30% co-insurance   |
| <b>Durable Medical Equipment</b><br>Prior authorization required if over \$5,000  | Network: 10% co-insurance<br>Non-Network: 30% co-insurance   |
| <b>Dialysis Services (Outpatient)</b>   | Network: 10% co-insurance<br>Non-Network (within CA): Plan pays 70% up to \$600/day; participant pays balance<br>Non-Network (outside CA): 30% co-insurance  |
| <b>Home Health Care and Hospice Services</b><br>Prior authorization required  | Network: 10% co-insurance<br>Non-Network: 30% co-insurance   |
| <b>Skilled Nursing and Rehabilitation Facility</b><br>100 days per Calendar Year limit  | Network: 10% co-insurance<br>Non-Network: 30% co-insurance   |
| <b>Outpatient Radiological/Nuclear Imaging and Spine Surgery/Pain Management Procedures (Non-Emergency)</b> Prior authorization required for non-emergency outpatient:<br>– Radiological/Nuclear Imaging (such as CT/PET scans, MRIs) - within California   | Network: 10% co-insurance<br>Non-Network: 30% co-insurance   |
| <b>Telemedicine Visit - 1-800-TELADOC</b><br>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.   |

*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  |
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| <p><b>Current and Prospective Members:</b><br/>1-888-235-1767<br/><a href="http://www.blueshieldca.com/oc">www.blueshieldca.com/oc</a></p> | <p><b>Current Members:</b><br/>1-800-573-3583<br/><a href="http://www.optumrx.com">www.optumrx.com</a></p> <p><b>Prospective Members:</b><br/>1-844-880-0759<br/><a href="https://www.optumrx.com/oe_countyoforange/landing">https://www.optumrx.com/oe_countyoforange/landing</a></p> |

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 tulong sa 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): 한국어도움이 필요하시면, 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): دیریکه سامه 1-866-346-7198 نفلته مرامش ادا افلته، سراف نایز ناگیار کهمک تفایرد یارده

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਵਿਰਥਾ ਵਰਵੇ 1-866-346-7198 'ਤੇ ਵਾਲ਼ ਵਰੇ

Khmer (ខ្មែរ): សូម ទាក់ទងមកលេខ 1-866-346-7198

Arabic (العربية): 1-866-346-7198: مقرا اذهى لاصتاب لصفته، اناجم تيرعلا تغلا في ذة دعاسملا لى ل واصل

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

Hindi (हिन्दी): मना खचर के सहायता के लिए, 1-866-346-7198 पर कॉल कर।

Thai (ไทย): สำหรับ ความช่วยเหลือ เป็น ใจจ้ ายโปรดโทร 1-866-346-7198  
ภาษาไทยโดยไม้มค