Wellwise (Non-Medicare) Retiree PPO Health Plan - 2025

blue of california

Deductible (Calendar Year) 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 Non-Network: $750 Individual/$1,500 Family
Out-of-Pocket Medical Maximum Benefit (Calendar Year) 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 Non-Network: $5,000 Individual/$10,000 Family ***EXCLUSIONS**: Pharmacy expenses; Costs of services not covered; Non-Network amounts in excess of Usual, Reasonable, and Customary (URC) amount (balance billing); and 20% coinsurance for failure to obtain pre-admission review for non-emergency hospitalization.
Prescription Drug Card Program through OptumRx – Tier 1 - Mostly Generic Drugs – Tier 2 - Preferred – Mostly Brand Name Drugs[1] – Tier 3 - Non-Preferred – Mostly Brand-Name[1] – Specialty Drugs[1] Covered drugs must be purchased through a Network Retail Pharmacy or approved Mail Order Service. Prior authorization is required for select drugs. Drug Exclusions: The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available.	No Calendar Year Deductible – Tier 1 - 20% coinsurance – Tier 2 - 25% coinsurance[1] – Tier 3 - 30% coinsurance[1] – Specialty Drugs - Percentage indicated for each tier above[1], up to a maximum of $150 per 30-day supply Out-of-Pocket Prescription Drug Maximum Benefit $4,100 Individual/$8,200 Family (Calendar Year) [1] 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. **Not included in the prescription drug out-of-pocket limit:** Drugs not covered by the plan; Drugs filled through Optum's enhanced savings program; and the cost differential between generic and brand name drug if member chooses brand name drug when a generic equivalent is available.
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)	
Preventive Care Services As set forth in Plan Document	No coinsurance and no deductible
Primary Care and Specialist Physician Office Visits, Laboratory Services, Urgent Care Facility, Rehabilitative Therapy, and Outpatient Surgery - Hospital	Network: 10% coinsurance Non-Network: 30% coinsurance
Medical - Inpatient Hospital Services	Network: 10% coinsurance Non-Network: 30% coinsurance; without pre-admission review, 50% coinsurance
Outpatient Surgery - Ambulatory Surgery Center (facility charges)	Network: 10% coinsurance Non-Network: Plan pays 70% up to $1,500/ day; member pays balance

Emergency Room Treatment Based on Plan Document "Emergency Services" definition	Medical condition ***does*** meet definition Network/Non-Network: 10% coinsurance Medical condition ***does NOT*** meet definition Network: 10% coinsurance Non-Network: 30% coinsurance *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% coinsurance Non-Network: 30% coinsurance; without pre-admission review for inpatient, 50% coinsurance
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% coinsurance Non-Network: 30% coinsurance
Durable Medical Equipment As set forth in the Plan Document	Network: 10% coinsurance Non-Network: 30% coinsurance
Hearing Aids	$5,000 per member; within any thirty-six month period
Dialysis Services (Outpatient)	Network: 10% coinsurance Non-Network (within CA): Plan pays 70% up to $600/day; member pays balance Non-Network (outside CA): 30% coinsurance
Home Health Care and Hospice Services Prior authorization required	Network: 10% coinsurance Non-Network: 30% coinsurance
Skilled Nursing and Rehabilitation Facility Prior authorization required 100 days per Calendar Year limit (combined Network/Non-Network)	Network: 10% coinsurance Non-Network: 30% coinsurance
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% coinsurance Non-Network: 30% coinsurance
Teladoc: 1-800-teladoc Access to board-certified doctors 24/7/365 who are ready to treat many non-emergency medical issues 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% coinsurance.

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 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://welcome.optumrx.com/countyoforange/landing

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): **Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' hodíílnih** 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): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 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): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi(ਪੰਜਾਬੀ):ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਿਹਰਬਾਨੀ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال 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): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।

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