blue of california

Coverage Period: 1/1/2024 – 12/31/2024

County of Orange Sharewell Choice-Active Employees **Coverage for:** Individual + Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit blueshieldca.com/oc or call **1-888-235-1767**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers and non-participating providers **$5,000** per family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. All **copayment** and **coinsurance** costs shown in this chart apply after your **deductible** has been met, if a **deductible** applies.
Are there services covered before you meet your deductible?	Yes. Preventive care listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,000** per family for participating providers; **$12,000** per family for non-participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, balance-billing charges, and penalties for failure to obtain pre-admission review for non- emergency hospitalization and the cost differential between the brand and generic drug if you choose a brand drug when a generic equivalent is available. See Prescription Dug section for limitations, exceptions, and other important information.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/oc or call **1-888-235-1767** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	----------None----------
If you visit a health care provider's office or clinic	Specialist visit	10% coinsurance	30% coinsurance	
If you visit a health care provider's office or clinic	Preventive care/screening /immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	----------None----------
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required for non-emergency Imaging (CT/PET scans, MRIs) within California. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Preventive drugs (in accordance with Health Care Reform)	0% coinsurance	Not Covered	Important Considerations: If member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the full cost differential between generic and brand cost, unless the prescriber specifically requests the brand name (dispense as written, do not substitute) The cost differential does not count towards the out-of-pocket limit for prescription drugs. 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. Drug Exclusions: The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available. Preauthorization is required for select drugs. Medication not covered by the plan including those filled through Optum's enhanced savings program will not count towards the annual deductible or out-of-pocket maximum.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: **Current members** www.optumrx.com **Prospective members** https://www.optumrx.com/oe_countyoforange/landing	Tier 1: Mostly generic drugs Tier 2: Mostly brand preferred drugs Tier 3: Mostly brand non-preferred drugs	20% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription specialty drug coverage is available at specialty.optumrx.com	Specialty drugs	20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Non-Participating Ambulatory Surgery Center: Up to a maximum of $1,500 per day.
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	*see comment below
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-network: Covered person is responsible for all charges above the current URC amount for Ground Ambulance but only responsible for in-network charges for air ambulance services.
If you need immediate medical attention	Urgent care	10% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

*For Non-Participating Provider who provides Emergency Services anywhere: Physicians Hospitals: the amount is the Reasoanable 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	----------None----------
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
If you are pregnant	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization is required for non-participating providers. Failure to obtain preauthorization may result in non-payment of benefits. When home health care is authorized as an alternative to continued hospitalization in a Network Hospital, the home health care services will be reimbursed at 90%
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	30% coinsurance	----------None----------
If you need help recovering or have other special health needs	Habilitation services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Skilled nursing care	10% coinsurance	30% coinsurance	Combined maximum of up to 100 days per calendar year; semi-private accommodations. Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need help recovering or have other special health needs	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required for equipment in excess of $5,000. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need help recovering or have other special health needs	Hospice services	Inpatient Respite Care 10% coinsurance	Inpatient Respite Care 30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. When Hospice residence immediately follows Inpatient services in a Network Hospital, the Hospice services will be reimbursed at 90%
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Covered under Preventive Services
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	----------None----------
If your child needs dental or eye care	Children's dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Shield Customer Service at 1-855-836-9705 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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, kwiji' 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 ਮਫ਼ਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាសម្រាប់ជនសញ្ជាតិគ្មានថ្លៃ សូមទាក់ទងមកលេខ1-866-346-7198.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of participating pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,860**

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,960**

Mia's Simple Fracture
(participating emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.