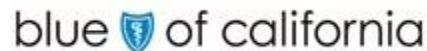


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



County of Orange Wellwise Choice - Active Employee

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

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 <u>deductible</u> ?	For participating providers \$500 individual/ \$1,000 family and <u>non-participating providers</u> \$750 individual/ \$1,500 family. <u>Doesn't apply to preventive care.</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> listed in your complete terms of coverage.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet separate <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: <u>participating providers</u> \$2,500 individual/ \$5,000 family; <u>non-participating</u> \$5,000 individual / \$10,000 family; Prescription Drug: \$4,100 individual/ \$8,200 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family <u>out-of-pocket limit</u> has been met.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care/screening</u> /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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for non-emergency Imaging (CT/PET scans, MRIs) within California. Failure to obtain <u>preauthorization</u> 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	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (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% <u>coinsurance</u>	Not Covered	<p>Preauthorization is required for select drugs. The formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available.</p> <p>Not included in the prescription drug out-of-pocket limit: Drugs not covered by the plan including those filled through Optum's enhanced savings program; and if member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the cost differential between generic and brand drug. The cost differential does not count towards the prescription drug out-of-pocket limit.</p>
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	20% <u>coinsurance</u>	Not Covered	
	Tier 2: Mostly brand preferred drugs	25% <u>coinsurance</u>	Not Covered	
	Tier 3: Mostly brand non-preferred drugs	30% <u>coinsurance</u>	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	Percentage indicated up to a maximum of \$150 per 30-day supply	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	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Non-Participating</u> Ambulatory Surgery Center: Up to a maximum of \$1,500 per day.
If you have outpatient surgery	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	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	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-admission review required. Penalty: <u>Non-Participating</u> 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% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

*For a Non-Participating Provider who provides Emergency Services anywhere: Physicians and Hospitals: the amount is the provider's billed charge for Covered Services, unless 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	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-admission review required. Penalty: <u>Non-Participating</u> only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined maximum of up to 100 days per calendar year; semi-private accommodations. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for equipment in excess of \$5,000. Failure to obtain <u>preauthorization</u> 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	<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Hospice services</u>	Inpatient Respite Care 10% <u>coinsurance</u>	Inpatient Respite Care 30% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> 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	• Infertility Treatment	• Private-duty nursing	• Routine foot care	
• Dental care (Adult)	• Long-term care	• Routine eye care (Adult)	• Weight loss programs	
• Hearing Aids				
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 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): Diné k'ehjí doo bąąh ílínígó shíka' at'ooowł nínízingo, kwijí' 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): 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): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਸਹਾਇਤਾ ਲਈ 1-866-346-7198 ਨੂੰ ਸੰਪਰਕ ਕਰੋ.

Khmer (ភាសាខ្មែរ): ប្រសិនបើអ្នកត្រូវការការជួយឥតគិតថ្លៃជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ 1-866-346-7198.

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

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

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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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.

Blue Shield of California is an independent member of the Blue Shield Association.