Wellwise Post-65 Retiree PPO Health Plan - 2024

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 URC (balance billing); and 20% co-insurance 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] – Tier 4 –Specialty Pharmacy and High Cost Drugs[1] Preauthorization 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% co-insurance – Tier 2 = 25% co-insurance[1] – Tier 3 = 30% co-insurance[1] – Specialty Drugs = Percentage indicated for each tier above, up to a maximum of $150 per 30-day supply Out-of-Pocket Prescription Drug Maximum Benefit $4,100 Individual(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. 1)Some higher cost Generic Drugs may be placed in the Preferrred Drug or Non-Preferred Dug Tier. 2)Member may request up to 90-day supply for specialty products if they are establish on therapy. Additional days supply above 30 would result in a maximum payment of $300 for a 60-day supply or $450 for a 90-day supply. 3)If you reach the catastrophic coverage state at $7400, you will pay 5% and minimum copay amount.
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 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: 10% co-insurance
Medical - Inpatient Hospital Services	Network: 10% co-insurance Non-Network: 30% co-insurance; without pre-admission review, 50% coinsurance
Outpatient Surgery - Ambulatory Surgery Center (facility charges)	Network: 10% co-insurance Non-Network: Plan pays 70% up to $1,500/ day; participant pays balance

Emergency Room Treatment Based on Plan Document "Emergency Services" definition	For a Non-Participating 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/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under federal law.
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
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 Prior authorization required	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
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	Network: 10% co-insurance Non-Network: 30% co-insurance
Telemedince Visit - 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% 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.

Not included in the prescription drug out-of-pocket limit: Drugs not covered by the plan; Drugs filled through Optum's enchanced savings program; and the cost differential between generic and brand drug if member chooses brand drug when a generic equivalent is available.

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://www.optumrx.com/oe_countyoforange/landing

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): Đểđược 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 بارب یاردیفاتکمک ریاگان نابز یسراف،افطل اب ًشامره نفلت 7198-346-866-1 سامتبگیرید. :)یسراف(

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

Khmer (��ែខ�រ)៖ សូ ួយ��អង់េគ�សេ�យឥតគិតៃថ� សូ ម�ក់ទងមកេលខ 1-866-346-
មជន់ 7198។

Arabic لحصول على المساعدة في اللغة العربية مجانا، تفضل بالاتصال على هذا الرقم: 7198-346-866-1. :)العربية(

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

Hindi (�हन्द�): �हन्द� म� �बना खचर् के सहायता के �लए, 1-866-346-7198

पर कॉल कर�।

Thai (ไทย): สำหรบั ความชว่ เป็ ่ ใชจ้ ายโปรดโทร 1-866-346-7198
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