County of Orange Retiree Medical Plan One Page Benefits Summaries

The following One Page Benefits Summaries contain information about your health plan options. Please review these summaries carefully to make the best coverage choices for you and your family.

Plans if you are NOT eligible for Medicare:
Wellwise Retiree PPO Sharewell Retiree PPO Kaiser Retiree HMO Anthem Blue Cross Select HMO Anthem Blue Cross Traditional HMO

Plans if you ARE eligible for Medicare:
Wellwise Retiree PPO Sharewell Retiree PPO Kaiser Senior Advantage HMO SCAN HMO Anthem Blue Cross Senior Secure HMO Anthem Blue Cross Custom PPO Anthem Blue Cross Standard PPO

If you need additional information please visit My OC Benefits™ at mybenefits.ocgov.com or call the Benefits Service Center at 1-833-476-2347 , 8 a.m. to 6 p.m., PT Monday – Friday, except holidays.

Wellwise Non-Medicare Retiree PPO Health Plan - 2023

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 – Preventive Drugs – as set forth in the Plan Document – Tier 1 - Mostly Generic Drugs – Tier 2 - Preferred – Mostly Brand Name Drugs[1] – Tier 3 - Non-Preferred – Mostly Brand-Name[1] – Specialty 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 – Preventive Drugs = 0% co-insurance – 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[1], up to a maximum of $150 per 30-day supply Out-of-Pocket Prescription Drug Maximum Benefit $4,100 Individual/$8,200Family (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 drug if member chooses brand 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 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 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.
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 (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
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): 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): 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: .دیریگب سامت 7198-346-866-1 نفلت مارمش باً فطا،یسراف نابز نگایر کمک دیافت دراي

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

Khmer (ខ្មែរ): សូ ួយ អង់េគ សេ យតតគិតៃថ្ង សូ ម ក់ទងមកេលខ 1-866-346-7198។ មជ្ឈំ

Arabic (العربية: .)7198-346-866-1 :اذه الرقم لاتصال على فضل ،انامجه العربية اللغة في المساعدة على للحصو

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

Hindi (हिन्दी): हिन्दी में बोलना चाहते हैं तो, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับ ความชว่ เป็ ช่ ใชจ้ ายโปรดโทร 1-866-346-7198 ยเหลอื นภาษาไทยโดยไมม่ค

Sharewell Retiree PPO Health Plan - 2023

blue of california

Family Deductible (Calendar Year) The Family Deductible must be satisfied before most covered Medical and Pharmacy expenses are reimbursed by the Plan.	$5,000 (combined Network and Non-Network) All covered Medical and Pharmacy Expenses accumulate toward both the Network and Non-network Deductible
Out-of-Pocket Maximum Benefit (Calendar Year) After all out-of-pocket expenses for incurred covered services (including deductibles and coinsurance) have totaled the amount shown, the PLAN will pay 100%.	Network: $6,000 Family Non-Network: $12,000 Family ***EXCLUSIONS**: Costs of medical and pharmacy services not covered; Non-Network amounts in excess of the Usual, Reasonable and Customary (URC) amount; and 20% co-insurance for failure to obtain pre-admission review for non-emergency hospitalization. See additional considerations and exclusions listed below for prescription drugs.
The Covered Person pays the following percentage of Covered Medical and Pharmacy expenses after the annual Calendar Year Family Deductible has been satisfied (except as noted below) **The non-network coinsurance is based on the URC for that service and the member is responsible for any balance billed.*	
Preventive Care Services and Drugs 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: 30% co-insurance
Medical - Inpatient Hospital Services	Network: 10% co-insurance Non-Network: 30% co-insurance; without pre-admission review, 50% co-insurance
Outpatient Surgery - Ambulatory Surgery Center (facility charges)	Network: 10% co-insurance Non-Network: Plan pays 70% up to $1,500/ day; participant responsible for balance
Emergency Room Treatment Based on Plan Document "Emergency Services" definition	Medical condition ***does*** meet definition Network/Non-Network: 10% co-insurance Medical condition ***does NOT*** meet definition Network: 10% co-insurance Non-Network: 10% co-insurance *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% 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

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% 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 Requires prior authorization	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
Telemedicine Visit: 1-800-TELADOC 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.
Prescription Drugs Coverage Prescription drugs are subject to the plan deductible. The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available.	20% co-insurance *IMPORTANT CONSIDERATIONS: 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. The cost differential does not accumulate towards the out-of-pocket maximum. 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. Medication not covered by the plan and filled through Optum's enhanced savings program will not count towards the annual deductible or out-of-pocket maximum.

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 Sharewell and Wellwise 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 ***Optum Specialty Pharmacy:*** 1-855-427-4682 specialty.optumrx.com

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.

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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.

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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): اگر برای دریافت کمک رایگان به زبان فارسی، با شماره تلفن 1-866-346-7198 تماس بگیرید.

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

Khmer (ភាសាខ្មែរ): សូមទូរស័ព្ទមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية، اتصل 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): हिन्दी में बोलने के सहायता के लिए, 1-866-346-7198

पर कॉल करें।

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

Disclosure Form Part One

233978 COUNTY OF ORANGE - RETIREES
Home Region: Southern California
1/1/23 through 12/31/23

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$20 per visit
Most physical, occupational, and speech therapy	$20 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	$30 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$20 per visit

(continues)

Mental Health Services	You Pay
Group outpatient mental health treatment	$10 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Eyeglasses or contact lenses:	
Eyeglass frame every 24 months	Amount in excess of $100 Allowance
Regular eyeglass lenses every 12 months	No charge
Contact lenses every 12 months	Amount in excess of $125 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology (“ART”) Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Anthem Blue Cross
Health. Join In.

Anthem Blue Cross Select (HMO)

1-877-359-9653 Customer Service Department for additional information

Annual Out-of-Pocket Maximum for Certain Services	$4,000 per Individual $8,000 per Family
Pharmacy - Calendar Year Deductible	30 Days $100 Deductible/Member
- Generic Drugs on the Prescription Drug List	50% of drug negotiated rate up to $5 Co-payment per prescription (Deductible Waived)
- Preferred Brand – Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List	45% of drug negotiated rate up to $25 Co-payment per prescription (when no generic equivalent available, deductible waived)
- Non-Preferred Brand – Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List (including Compound Drugs)	45% of drug negotiated rate up to $45 Co-payment per prescription
- Self-Administered Injectable Drugs, except Insulin - Rx Choice Tiered Network	20% of drug negotiated rate (maximum of $100 co-payment) Level 1: Applicable retail copays apply Level 2: Applicable retail copays apply plus an additional $5.00.
Inpatient Hospital Services	No Co-payment per visit
Outpatient Facility Services	No Co-payment per visit
Hospital Emergency Room or Outpatient Facility	$100 copayment per visit, waived if admitted
Urgent Care Facility	$20 Co-payment per visit
Rehabilitative Therapy	$20 Co-payment per visit
Primary Care and Specialist Physician Office Visits	$20 Co-payment per visit Primary Care $40 Co-payment per visit Specialist
LiveHealth Online visits	$0 Co-payment per visit
Preventative Services: Annual Physical Exam Well Woman Exam	 No Co-payment No Co-payment
Routine Vision Care: Eye Exam	No Co-payment
Vision Care: One Pair of Approved Glasses	Not Covered
Durable Medical Equipment	No Co-payment
External Prosthetic Appliances	No Co-payment
Home Health Services (100 visits maximum per calendar year; one visit by home health aide equals four hours or less)	No Co-payment
Hospice Services	No Co-payment

Skilled Nursing and Rehabilitation Facilities (100 visits maximum per member per calendar year)	No Co-payment
Laboratory and Radiology Services	No Co-payment
Mental Health Inpatient Services	No Co-payment
Mental Health Outpatient Services	$20 Co-payment per visit
Substance Abuse Detoxification Inpatient Services	No Co-payment per visit
Substance Abuse Detoxification Outpatient Services	$20 Co-payment per visit

Additional Programs offered:
90 Days Mail Drug Order $100 Deductible/Member
Generic = 50% of drug negotiated rate up to $10 Co-payment per prescription (Deductible Waived)

Brand Name = 45% Of drug negotiated rate up to $50 Co-payment per prescription (when no generic equivalent available, deductible waived)

Non-Formulary = 45% Of drug negotiated rate up to $90 Co-payment per prescription

Self-Administered Injectable Drugs, except Insulin = 20% of drug negotiated rate (maximum of $200 co-payment)

Level 1 copays shown. For Level 2, apply an additional $10 to the mail order copays.

The Rx Choice Tiered Network includes pharmacies that give you more choices and flexibility when you fill prescriptions. It's also convenient — you'll find many popular grocery chains, stores and independent drugstores in the network. You can keep using the pharmacy you've been using, but you'll pay more for your prescription drugs unless you transfer your prescription(s) as soon as possible to another participating pharmacy. You can choose a pharmacy from two levels. Level 1 has up to 25,000 pharmacies and offers you a lower copay or coinsurance (the part you pay for your drugs) than pharmacies in Level 2. Filling prescriptions at a Level 1 pharmacy will help you lower your out-of-pocket costs.

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡 CA Dept. of Insurance。(TTY/TDD: 711)

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721
با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi
बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

MCASH4788CML 06/16 CDI3 CDIW1

Hmong
Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357
(TTY/TDD: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Anthem Blue Cross
Health. Join In.

Anthem Blue Cross Traditional HMO

1-877-359-9653 Customer Service Department for additional information

Annual Out-of-Pocket Maximum for Certain Services	$3,000 per Individual $6,000 per Family
Pharmacy	30 Days
- Generic Drugs on the Prescription Drug List	$5 Co-payment per prescription
- Preferred Brand – Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent	$25 Co-payment per prescription
- Non-Preferred Brand – Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List (including Compound Drugs)	$45 Co-payment per prescription
- Self-Administered Injectable Drugs, except Insulin	20% of prescription drug maximum allowed (maximum $100 co-payment)
- Rx Choice Tiered Network	Level 1: Applicable retail copays apply Level 2: Applicable retail copays apply plus an additional $5.00.
Inpatient Hospital Services	100% after $100 per admission Co-payment
Outpatient Facility Services	No Co-payment per visit
Hospital Emergency Room or Outpatient Facility	$50 Co-payment per visit, waived if admitted
Urgent Care Facility	$20 Co-payment per visit
Rehabilitative Therapy	$20 Co-payment per visit
Primary Care and Specialist Physician Office Visits	$20 Co-payment per visit Primary Care $20 Co-payment per visit Specialist
LiveHealth Online visits	$0 Co-payment per visit
Preventative Services: Annual Physical Exam Well Woman Exam	 No Co-payment No Co-payment
Routine Vision Care: Eye Exam	No Co-payment
Vision Care: One Pair of Approved Glasses	Not Covered
Durable Medical Equipment	No Co-payment
External Prosthetic Appliances	No Co-payment
Home Health Services *(100 visits maximum per calendar year; one visit by home health aide equals four hours or less)*	No Co-payment
Hospice Services	No Co-payment
Skilled Nursing and Rehabilitation Facilities (100 visits maximum per member per calendar year)	No Co-payment
Laboratory and Radiology Services	No Co-payment
Mental Health Inpatient Services	No Co-payment per visit
Mental Health Outpatient Services	$20 Co-payment per visit

Substance Abuse Detoxification Inpatient Services	No Co-payment per visit
Substance Abuse Detoxification Outpatient Services	$20 Co-payment per visit

Additional Programs offered:
90 Days Mail Drug Order
Generic = $10 Co-payment per prescription

Brand Name = $50 Co-payment per prescription

Non-Formulary = $90 Co-payment per prescription

Self-Administered Injectable Drugs, except Insulin = 20% prescription drug maximum allowed amount (maximum of $100 co-payment)
Level 1 copays shown. For Level 2, apply an additional $10 to the mail order copays.

The Rx Choice Tiered Network includes pharmacies that give you more choices and flexibility when you fill prescriptions. It's also convenient — you'll find many popular grocery chains, stores and independent drugstores in the network. You can keep using the pharmacy you've been using, but you'll pay more for your prescription drugs unless you transfer your prescription(s) as soon as possible to another participating pharmacy. You can choose a pharmacy from two levels. Level 1 has up to 25,000 pharmacies and offers you a lower copay or coinsurance (the part you pay for your drugs) than pharmacies in Level 2. Filling prescriptions at a Level 1 pharmacy will help you lower your out-of-pocket costs.

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

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MCASH4788CML 06/16 CDI3 CDIW1

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សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357
(TTY/TDD: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Wellwise Retiree PPO Health Plan - 2023

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 – Preventive Drugs – as set forth in the Plan Document – Tier 1 - Mostly Generic Drugs – Tier 2 - Preferred – Mostly Brand Name Drugs[1] – Tier 3 - Non-Preferred – Mostly Brand-Name[1] – Specialty 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 – Preventive Drugs = 0% co-insurance – Tier 1 = 20% co-insurance – Tier 2 = 25% co-insurance[1] – Tier 3 = 30% co-insurance[1] – Specialty Drugs = 30% up to a maximum of $150 per 30-day supply Out-of-Pocket Prescription Drug Maximum Benefit $4,100 Individual/$8,200Family (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 drug if member chooses brand 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 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 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.
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(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 services.	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
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): 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): 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: .دیریگب سامت 7198-346-866-1 نفلت مارمش باً فطا،یسراف نابز نگایر کمک دیافت دراي

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

Khmer (ខ្មែរ): សូ ួយ អង់េគ សេ យតតគិតៃថ្ង សូ ម ក់ទងមកេលខ 1-866-346-7198។ មជ្ឈំ

Arabic (العربية: .)7198-346-866-1 :اذه الرقم لاتصال على فضل ،انامجه العربية اللغة في المساعدة على للحصو

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

Hindi (हिन्दी): हिन्दी में बोलना चाहते हैं तो, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับ ความชว่ เป็ ช่ ใชจ้ ายโปรดโทร 1-866-346-7198 ยเหลอื นภาษาไทยโดยไมม่ค

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/23—12/31/23)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:	
For any one Member	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Annual Wellness visit and the “Welcome to Medicare” preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$20 per visit
Urgent care consultations, evaluations, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)	
Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge
Other transportation Services when provided by our designated transportation provider as described in this *EOC*	No charge for up to 24 one-way trips (50 miles per trip) per calendar year
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply

continued

Prescription Drug Coverage	You Pay
Most brand-name items	$35 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Meals delivered to your home following discharge from a hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

SCAN Health Plan January 1, 2023	
Annual Maximum Out of Pocket for Medical Co-pays Pharmacy	$3,000 per member
• **Generic Drugs** on the Prescription Drug List	$10 copay per prescription ($5 when using preferred pharmacy)
• **Preferred Brand** Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent	$20 copay per prescription
• **Non-Preferred Brand** Non-Medically Necessary Name BrandDrugs on the Prescription Drug List with a Generic Equivalentand drugs designated non-preferred on the Prescription Drug List	$20 copay per prescription
• **Specialty Drugs**	25% coinsurance
100-days supply available at retail pharmacy or mail order through ESI	Two copays for 100-days supply
Inpatient Hospital Services	$100 copay per admission
Outpatient Facility Services	$0 copay
Hospital Emergency Room or Outpatient Facility	$50 copay per visit, waived if admitted
Urgent Care Facility	$15 copay per visit
Rehabilitative Therapy	$15 copay per visit
Primary Care and Specialist Physician Office Visits	$15 copay per visit
Preventive Services: Annual Physical ExamWell Woman Exam	 $0 copay per visit $0 copay per visit
Chiropractic Service: For the diagnosis and treatment of disorders neuromusculoskeletal system	$15 copay per visit; up to 20-self-referred visits
Vision Care: Eye Exam	$15 copay per visit
Vision Care: One Pair	$100 allowance towards glasses; $0 copay for lenses' $130 contact allowance in lieu of glasses
Hearing ExamHearing Aids	$15 copay $300 allowance per aid; or $600 for two aids every two calendar years
Durable Medical Equipment	$0 copay
External Prosthetic Appliances	$0 copay
Home Health Services	$0 copay
Hospice Services	$0 copay
Skilled Nursing and Rehabilitation Facilities	$0 copay
Laboratory and Radiology Services	$0 copay
Mental Health Inpatient Services	$100 copay per admission
Mental Health Outpatient Services	$15 copay per visit
Substance Abuse Detoxification Inpatient Services	$100 copay per admission
Substance Abuse Detoxification Outpatient Services	$10 copay per visit
Gym Membership Telehealth Transportation unlimited rides; 75 miles maximum per ride BrainHQ SCAN Healthtech Abridge Abridge App Headspace App Chronic Home Delivered Meals Solutions for Togetherness Nurse Advice Line	$0 copay $0 copay $0 copay $0 copay $0 copay $0 copay $0 copay $0 copay $0 copay $0 copay $0 copay
Additional Services & Programs offered: Prospective members please contact SCAN Health Plan at 1-877-212-7654. SCAN is available to assist you in	

reviewing SCAN benefits, primary care selection, prescription drug formulary, and coordination of service for pre-arrangement procedures. For member related questions, please contact Member Services at 1-800-559-3500.

Independent Living Power®
SCAN offers unique in-home services designed to keep people on Medicare healthy and independent. Called Independent Living Power, these services can help during a recovery from a hospital stay or provide support during an acute of long-term illness. For many retirees, these benefits provide the extra help necessary to remain out of a nursinghome. Qualifying members are eligible for up to $650 allowance per month of these additional services. Retirees mustqualify for Independent Living Power. Services are only available in Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties.

Personal Care Coordinator $0 copay
SCAN staff will provide personal assistance to coordinate your Independent Living Power services or other serviceswith within SCAN and refer members to community resources.

Home Delivered Meals $0 copay
SCAN members are covered for home delivery of meals to meet nutritional needs.

Personal Care $15 copay/visit
You are covered for in-home assistance for tasks such as bathing, dressing, eating, getting in and out of bed, movingabout/walking, and grooming.

Emergency Response System $0 per month
SCAN members are covered for the installation of a personal emergency response device that alerts emergency medicalpersonnel to provide immediate help. There is no cost for installation.

Routine Transportation $0 copay
Unlimited rides per year to or from pre-scheduled medical appointment to contracted providers.75 miles maximum per ride.

Transportation Escort $15 copay
As a SCAN member you are eligible to receive an escort to assist you during transportation to and from medicalappointments.

Homemaker Service $15 copay
SCAN members are eligible to receive assistance with light cleaning, grocery shopping, laundry, and meal preparation.

Inpatient Custodial Level Care $0 copay
You are covered for up to five days for post-acute or respite support in and in-patient facility such as a skilled nursingfacility. You may use this services following a hospital discharge, ER visit, or for respite care purposes.

In-Home Caregiver Relief $15 copay
SCAN provides alternative caregiver services in your home when a regular caregiver can't be there.

Adult Day Care $15 copay
SCAN covers adult day care services to provide relief for your regular Caregiver while addressing the individual needsof the member for physical, social, or intellectual exercises and stimulation.

Incontinence supplies/Hygiene supplies $0 copay
SCAN covers incontinence supply if members are living in Assisted Living Facility or Board and Care or at Homewhen they are wheelchair bound or bedbound.

Select Bathroom Safety Equipment $0 copay

Anthem Senior Secure (HMO)

County of Orange - HMO Plan

Effective January 1, 2023

For additional information, contact First Impressions:
Pre Member: 1-833-848-8729 / Member: 1-833-848-8730

Pharmacy - Retail – Generic Drugs on the Prescription Drug List – Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent – Non-Preferred Brand - Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List	<table><tr><th>Preferred Pharmacy</th><th>Non Preferred Pharmacy</th></tr><tr><td>$0 copay Select Generics</td><td>$0 copay Select Generics</td></tr><tr><td>$5 copay Generics</td><td>$10 copay Generics</td></tr><tr><td>$25 copay Preferred Brand</td><td>$30 copay Preferred Brand</td></tr><tr><td>$45 copay Non-preferred Brand and Specialty</td><td>$50 copay Non-preferred Brand and Specialty</td></tr></table>
Annual Out-Pocket Maximum for Certain Services	$3000 for each Medicare eligible retiree
Outpatient Facility Services	$100 copayment
Hospital Emergency Room or Outpatient Facility	$50 copayment per visit, waived if admitted
Urgent Care Facility	$20 copayment per visit
Rehabilitative Therapy	$20 copayment per visit
Primary Care and Specialist Physician Office Visits	$20 copayment per visit
Preventative Services: Annual Physical Exam Well Woman Exam	 $0 copayment per visit $0 copayment per visit
Routine Vision Care: Eye Exam	Through Blue View Vision $20 copayment for exam every 12 months
Routine Vision Care: One Pair of Approved Glasses	$100 allowance for Frames every 24 months$0 copayment for lenses every 24 months$80 allowance for contact lenses every 24 months in lieu of glasses
Durable Medical Equipment	20% coinsurance
External Prosthetic Appliances	20% coinsurance
Home Health Services	$0 copayment
Hospice Services	$20 copayment for consultation. Original Medicare covers Hospice care
Skilled Nursing and Rehabilitation Facilities	$0 copayment per admission
Laboratory and Radiology Services	$0 copayment for Laboratory tests$20 copayment for simple X-rays$100 copayment for complex X-rays
Mental Health Inpatient Services	$100 copayment per admission
Mental Health Outpatient Services	$20 copayment per visit
Substance Abuse Inpatient Services	$100 copayment per admission
Substance Abuse Outpatient Services	$20 copayment per visit

Additional Services & Programs offered:

Health & Wellness Programs
24-hour Nurseline and Audio Library
SilverSneakers - Opportunities to join in fitness programs and health education seminars
LiveHealth Online - Telehealth visits with an in-network board certified doctor available 24/7
Healthy Meals (Healthy Food Delivery)
Healthy Groceries Card
Medicare Community Resource Support
Smoking Cessation
Foreign Travel Benefit

For claims and other questions once you become a member, please call:
1-833-848-8730 TTY users: 711, Monday- Friday 8:00 a.m. - 9:00 p.m. ET

County of Orange website: http://anthem.com/ca/countyoforange

Note: The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.

- You must receive all routine care from plan providers.
- Eligible beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits may change on January 1 of each year.

Anthem

Anthem Preferred Custom (PPO)

County of Orange - PPO Plan

Effective January 1, 2023

For additional information, contact First Impressions:
Pre Member: 1-833-848-8729 / Member: 1-833-848-8730

<table>
<tr><td>Pharmacy - Retail
– Generic Drugs on the Prescription Drug List
– Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent
– Non-Preferred Brand - Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List</td><td><table>
<tr><td>Preferred Pharmacy</td><td>Non Preferred Pharmacy</td></tr>
<tr><td>$0 copay Select Generics</td><td>$0 copay Select Generics</td></tr>
<tr><td>$5 copay Generics</td><td>$10 copay Generics</td></tr>
<tr><td>$25 copay Preferred brand</td><td>$30 copay Preferred Brand</td></tr>
<tr><td>$45 copay Non-preferred Brand and Specialty</td><td>$50 copay Non-preferred Brand and Specialty</td></tr>
</table></td></tr>
<tr><td>Annual Out-Pocket Maximum for Certain Services</td><td>$3250.00</td></tr>
<tr><td>Outpatient Facility Services</td><td>$20 copayment</td></tr>
<tr><td>Hospital Emergency Room or Outpatient Facility</td><td>$50 copayment per visit, waived if admitted</td></tr>
<tr><td>Urgent Care Facility</td><td>$20 copayment per visit</td></tr>
<tr><td>Rehabilitative Therapy</td><td>$20 copayment per visit</td></tr>
<tr><td>Primary Care and Specialist Physician Office Visits</td><td>$20 copayment per visit</td></tr>
<tr><td>Preventive Services:
Annual Physical Exam
Well Woman Exam</td><td>
$0 copayment per visit
$0 copayment per visit</td></tr>
<tr><td>Routine Vision Care: Eye Exam</td><td>$0 copayment per visit</td></tr>
<tr><td>Routine Vision Care: One Pair of Approved Glasses</td><td>$150 allowance for Eye wear every 24 months</td></tr>
<tr><td>Durable Medical Equipment</td><td>$0 copayment</td></tr>
<tr><td>External Prosthetic Appliances</td><td>$0 copayment</td></tr>
<tr><td>Home Health Services</td><td>$0 copayment</td></tr>
<tr><td>Hospice Services</td><td>$20 copayment for consultation. Original Medicare covers Hospice care</td></tr>
<tr><td>Skilled Nursing and Rehabilitation Facilities</td><td>$0 copayment per admission</td></tr>
<tr><td>Laboratory and Radiology Services</td><td>$0 copayment</td></tr>
<tr><td>Mental Health Inpatient Services</td><td>$100 copayment per admission</td></tr>
<tr><td>Mental Health Outpatient Services</td><td>$20 copayment per visit</td></tr>
<tr><td>Substance Abuse Inpatient Services</td><td>$100 copayment per admission</td></tr>
<tr><td>Substance Abuse Outpatient Services</td><td>$20 copayment per visit</td></tr>
</table>

Additional Services & Programs offered:
Health & Wellness Programs
24-hour Nurseline and Audio Library
SilverSneakers - Opportunities to join in fitness programs and health education seminars LiveHealth Online - Telehealth visits with an in-network board certified doctor aavailable 24/7
Healthy Meals (Healthy Food Delivery)
Healthy Groceries Card
Medicare Community Resource Support
Smoking Cessation
Foreign Travel Benefit

For claims and other questions once you become a member, please call:
1-833-848-8730 TTY users: 711, Monday- Friday 8:00 a.m. - 9:00 p.m. ET.

County of Orange website: http://anthem.com/ca/countyoforange

Note: The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.
- Eligible beneficiaries must use network pharmacies to access their prescription drug benefits, except under non-routine circumstances and quantity limitations and restrictions may apply.

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Anthem Blue Cross Life and Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Anthem

Anthem Preferred Standard (PPO)
County of Orange - HMO Plan
Effective January 1, 2023

For additional information, contact First Impressions:
Pre Member: 1-833-848-8729 / Member: 1-833-848-8730

<table>
<tr><td>Pharmacy - Retail

– Generic Drugs on the Prescription Drug List

– Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent

– Non-Preferred Brand - Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List</td><td>$200 deductible<table><tr><td>Preferred Pharmacy</td><td>Standard Network Pharmacy</td></tr><tr><td>$0 copay Select Generics</td><td>$0 copay Select Generics</td></tr><tr><td>$10 copay Generics</td><td>$15 copay Generics</td></tr><tr><td>$40 copay Preferred Brand</td><td>$45 copay Preferred Brand</td></tr><tr><td>$40 copay Non - Preferred Brand</td><td>$45 copay Non - Preferred Brand</td></tr><tr><td>$40 copay Specialty</td><td>$45 copay Specialty</td></tr></table></td></tr>
<tr><td>Annual Deductible</td><td>$300</td></tr>
<tr><td>Annual Out-Pocket Maximum for Certain Services</td><td>$3400 combined Network and Non-network for each Medicare eligible retiree</td></tr>
<tr><td>Inpatient Hospital Services</td><td>Network - $200 copayment, days 1-5
Non-network - 30% coinsurance per admission</td></tr>
<tr><td>Outpatient Facility Services</td><td>Network - $100 co-payment
Non-network - 30% coinsurance</td></tr>
<tr><td>Hospital Emergency Room or Outpatient</td><td>$65 copayment per visit, waived if admitted</td></tr>
<tr><td>Urgent Care Facility</td><td>$40 copayment per visit</td></tr>
<tr><td>Rehabilitative Therapy</td><td>Network - $40 copayment per visit
Non-network - 30% coinsurance</td></tr>
<tr><td>Primary Care and Specialist Physician Office Visits</td><td>Network - $25 copayment for Primary Care physician per visit & $40 copayment for Specialist per visit
Non-network - 30% coinsurance per visit</td></tr>
<tr><td>Preventative Services:
Annual Physical Exam

Well Woman Exam</td><td>Network - $0 copayment per visit
Non-network 30% coinsurance per visit

Network - $0 copayment per visit
Non-network 30% coinsurance</td></tr>
<tr><td>Routine Vision Care: Eye Exam</td><td>$0 copayment for Network and Non-network routine vision exams</td></tr>
<tr><td>Eyewear</td><td>$100 maximum benefit allowance every 24 months. Covered eye wear includes prescription glasses, lenses, frames and contact lenses.</td></tr>
</table>

Durable Medical Equipment	Network - 10% coinsurance Non-network - 10% coinsurance
External Prosthetic Appliances	Network - 10% coinsurance Non-network - 10% coinsurance
Home Health Services	Network - $0 copayment Non-network - 30% coinsurance
Hospice Services	Network - $40 copayment for consultation Non-network - 30% coinsurance for consultation Original Medicare pays for Hospice Services
Skilled Nursing and Rehabilitation Facilities	Network - $0 per days 1-20, $50 per days 21-100 Non-network - 30% coinsurance per admit
Laboratory and Radiology Services	Lab Network $0 copayment Non-network - $0 copayment X-ray Network - $40 copayment for simple and $125 for complex Non-network - 30% coinsurance
Mental Health Inpatient Services	Network $200 copayment, days 1-5 Non-network-30% coinsurance per admit
Mental Health Outpatient Services	Network - $25 copayment per visit Non-network - 30% coinsurance
Substance Abuse Detoxification Inpatient Services	Network $200 copayment, days 1-5 Non-network-30% coinsurance per admit
Substance Abuse Detoxification Outpatient Services	Network - $25 copayment per visit Non-network - 30% coinsurance

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- With the exception of emergencies or urgent care, it may cost more to get care from out-of-network providers.
- Eligible beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply.