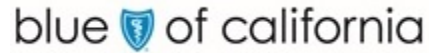



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services




Coverage Period: 1/1/2025 – 12/31/2025

County of Orange Sharewell Choice

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](https://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](https://healthcare.gov/sbc-glossary) or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall deductible?</b></p>	<p>For <u>participating providers</u> and <u>non-participating providers</u> <b>\$5,000</b> per family.</p>	<p>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.</p> <p> All <b>copayment</b> and <b>coinsurance</b> costs shown in this chart apply after your <u>deductible</u> has been met, if a <u>deductible</u> applies.</p>
<p><b>Are there services covered before you meet your deductible?</b></p>	<p>Yes. <u>Preventive care</u> listed in your complete terms of coverage.</p>	<p>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 <a href="https://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p><b>Are there other deductibles for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet separate <u>deductibles</u> for specific services.</p>
<p><b>What is the out-of-pocket limit for this plan?</b></p>	<p><b>\$6,000</b> per family for <u>participating providers</u>; <b>\$12,000</b> per family for <u>non-participating providers</u>.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.</p>

Important Questions	Answers	Why This Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, <u>balance-billing</u> charges, and penalties for failure to obtain pre-admission review for non-emergency hospitalization and the cost differential between the brand and generic drug if you choose a brand drug when a generic equivalent is available. See Prescription 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://blueshieldca.com/oc">blueshieldca.com/oc</a> or call <b>1-888-235-1767</b> 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 ( <u>Participating Provider</u> ). You will pay the most if you use an <u>out-of-network provider</u> ( <u>Non-Participating 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you visit a health care <u>provider's</u> office or clinic</b>	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you visit a health care <u>provider's</u> office or clinic</b>	<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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you have a test</b>	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
<b>If you need drugs to treat your illness or condition</b>	Preventive drugs (in accordance with Health Care Reform)	0% <u>coinsurance</u>	Not Covered	<p>Important Considerations:</p> <p>Drug Exclusions: The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available. Preauthorization is required for select drugs.</p> <p>If member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the full cost differential between generic and brand cost, unless the prescriber specifically requests the brand name (dispense as written, do not substitute). The cost differential does not count towards the out-of-pocket limit.</p> <p>Medication not covered by the plan including those filled through Optum's enhanced savings program will not count towards the annual deductible or out-of-pocket maximum.</p> <p>All Specialty Drugs must be fulfilled by Optum Specialty Pharmacy in order to be covered. Manufacturer specialty coupon cards do not count towards the annual deductible or out-of-pocket maximum.</p>
<b>If you need drugs to treat your illness or condition</b> More information about prescription drug coverage is available at:  <b>Current members</b> <a href="http://www.optumrx.com">www.optumrx.com</a>  <b>Prospective members</b> <a href="https://welcome.optumrx.com/countyoforange/landing">https://welcome.optumrx.com/countyoforange/landing</a>	Tier 1: Mostly generic drugs  Tier 2: Mostly brand preferred drugs  Tier 3: Mostly brand non-preferred drugs	20% <u>coinsurance</u>	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about prescription specialty drug coverage is available at <a href="http://specialty.optumrx.com">specialty.optumrx.com</a>	Specialty drugs	20% <u>coinsurance</u>	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
<b>If you have outpatient surgery</b>	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.
<b>If you have outpatient surgery</b>	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----None-----
<b>If you need immediate medical attention</b>	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Non-Participating</u> : Member is responsible for all charges above the current Usual, Reasonable and Customary (URC) amount for ground ambulance but only responsible for in-network charges for air ambulance services.
<b>If you need immediate medical attention</b>	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-admission review required. <u>Non-Participating</u> : If the member does not have the required pre-admission review before the hospital stay, then what you will pay is increased to 50% <u>coinsurance</u> .
<b>If you have a hospital stay</b>	Physician/surgeon fees	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.  Applied Behavioral Analysis: Coverage limited to <u>Participating Providers</u> only.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-admission review required. <u>Non-Participating</u> : If the member does not have the required pre-admission review before the inpatient services starts, then what you will pay is increased to 50% <u>coinsurance</u> .
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<b>If you are pregnant</b>	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you are pregnant</b>	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>	<u>Preauthorization</u> is required for <u>Non-Participating</u> providers. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. When home health care is authorized as an alternative to continued hospitalization in a Participating Hospital, you will pay 10% <u>coinsurance</u> .
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 Participating Hospital, you will pay 10% <u>coinsurance</u> for the hospice services.
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:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>			
• Cosmetic surgery	• Infertility treatment	• Private-duty nursing	• Routine foot care
• Dental care (Adult)	• Long-term care	• Routine eye care (Adult)	
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>			
• Acupuncture	• Chiropractic care	• Hearing aids	• Orthotics
• Bariatric surgery	• Continuous glucose monitors	• 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 <https://www.cms.gov/marketplace/about/oversight>. 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](http://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 1-888-235-1767 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/agencies/ebsa](https://dol.gov/agencies/ebsa).

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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'oowoł 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 կարգապահության օգնությունը առանց փողատրամադրության է կազմակերպվում 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): پنجابی وج مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو۔

Khmer (ភាសាខ្មែរ): សូមទំនួលយកសេវាសង្គមសម្រាប់ជនគ្រោះថ្នាក់ 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): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।

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

—————To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.—————

About these Coverage Examples:



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

**Peg is Having a Baby**

(9 months of participating pre-natal care and a hospital delivery)

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

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,860</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine participating care of a well-controlled condition)

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

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,960</b>

**Mia's Simple Fracture**

(participating emergency room visit and follow up care)

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

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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.



## NOTICES AVAILABLE ONLINE

### **Nondiscrimination and Language Assistance Services**

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: [blueshieldca.com/notices](https://blueshieldca.com/notices). You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

### **Servicios de asistencia en idiomas y avisos de no discriminación**

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en [blueshieldca.com/notices](https://blueshieldca.com/notices). Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.