blue of california

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

County of Orange Wellwise 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 or call **1-888-235-1767**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Preventive drugs (in accordance with Health Care Reform)	0% coinsurance	Not Covered	Preauthorization is required for select drugs. The formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available. **Not included in the prescription drug out-of-pocket limit:** Drugs not covered by the plan including those filled through Optum's enhanced savings program; and if member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the cost differential between generic and brand drug. The cost differential does not count towards the prescription drug out-of-pocket limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: **Current members** www.optumrx.com **Prospective members** https://welcome.optumrx.com/countyoforange/landing	Tier 1: Mostly generic drugs	20% coinsurance	Not Covered	
	Tier 2: Mostly brand preferred drugs	25% coinsurance	Not Covered	
	Tier 3: Mostly brand non-preferred drugs	30% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription specialty drug coverage is available at specialty.optumrx.com	Specialty drugs	Percentage indicated up to a maximum of $150 per 30-day supply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Non-Participating Ambulatory Surgery Center: Up to a maximum of $1,500 per day.
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	----------None----------
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-Participating: 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.
If you need immediate medical attention	Urgent care	10% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-admission review required. Non-Participating: If the member does not have the required pre-admission review before the hospital stay, then what you will pay is increased to 50% coinsurance.
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain preauthorization may result in non-payment of benefits. Applied Behavioral Analysis: Coverage limited to Participating Providers only.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	30% coinsurance	Pre-admission review required. Non-Participating: If the member does not have the required pre-admission review before the hospital stay, then what you will pay is increased to 50% coinsurance.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	----------None----------
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
If you are pregnant	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	----------None----------

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Hospice services	Inpatient Respite Care 10% coinsurance	Inpatient Respite Care 30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. When hospice residence immediately follows inpatient services in a Participating Hospital, you will pay 10% coinsurance 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:

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

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Continuous glucose monitors
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Orthotics

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 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.

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 tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): **Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji̜' hodíílnih** 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): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): **日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。**

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

Punjabi(پنجابی): پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو۔

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាខ្មែរដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

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

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

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,214
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,774**

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

The plan's overall deductible	$500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$504
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,064**

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

The plan's overall deductible	$500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$230
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$730**

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

blue california

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**. 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**. 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)**.