



Wellwise Retiree PPO Health Plan - 2020

blue of california

<p>Deductible (Calendar Year) Each Covered Person must satisfy the Annual Calendar Year Deductible before most Covered Medical Expenses are reimbursed by the PLAN.</p>	<p>Network: \$500 Individual/\$1,000 Family Non-Network: \$750 Individual/\$1,500 Family</p>
<p>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%.</p>	<p>Network: \$2,500 Individual/\$5,000 Family Non-Network: \$5,000 Individual/\$10,000 Family</p> <p>*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.</p>
<p>Prescription Drug Card Program through OptumRx</p> <ul style="list-style-type: none"> - Tier 1 - Mostly Generic Drugs - Tier 2 - Preferred – Mostly Brand Name Drugs¹ - Tier 3 - Non-Preferred – Mostly Brand-Name¹ - Specialty Drugs¹ <p><u>Drug Exclusions:</u> The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available.</p>	<p>No Calendar Year Deductible</p> <ul style="list-style-type: none"> - 20% co-insurance - 25% co-insurance¹ - 30% co-insurance¹ - Percentage indicated for each tier above¹, up to a maximum of \$150 per 30-day supply <p>Out-of-Pocket Prescription Drug Maximum Benefit \$4,100 Individual/\$8,200 Family (Calendar Year)</p> <p>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. The cost differential does not accumulate towards the out-of-pocket prescription drug maximum.</p>
<p>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)</p>	
<p>Preventive Care Services As set forth in Plan Document</p>	<p>No co-insurance and no deductible</p>
<p>Primary Care and Specialist Physician Office Visits, Laboratory and Radiology Services, Urgent Care Facility, Rehabilitative Therapy, and Outpatient Surgery - Hospital</p>	<p>Network: 10% co-insurance Non-Network: 30% co-insurance</p>
<p>Medical - Inpatient Hospital Services</p>	<p>Network: 10% co-insurance Non-Network: 30% co-insurance; without pre-admission review, 50% coinsurance</p>
<p>Outpatient Surgery - Ambulatory Surgery Center (facility charges)</p>	<p>Network: 10% co-insurance Non-Network: Plan pays 70% up to \$1,500/day; participant pays balance</p>
<p>Emergency Room Treatment Based on Plan Document "Emergency Services" definition</p>	<p>Medical condition does meet definition Network/Non-Network: 10% co-insurance</p> <p>Medical condition does NOT meet definition Network: 10% co-insurance Non-Network: 30% co-insurance</p> <p>*Non-Network - covered person is responsible for all charges incurred above the URC amount.</p>

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
Teladoc: 1-800-teladoc Access to board-certified doctors 24/7/365 who are ready to treat many non-emergency medical issues at a lower cost than an office visit or urgent care. With Teladoc's convenient phone and online video appointments, you can save a trip to the doctor's office. Teladoc is an in-network service.	Once you have met your deductible, you pay the 10% co-insurance.

This is only a summary of benefits. This chart contains the major features of the plan and is not intended to replace the Plan Document containing the complete provisions.

Contact Information

Blue Shield of California	OptumRx
<p>Current and Prospective Wellwise Members 1-888-235-1767 www.blueshieldca.com/oc</p>	<p>Prospective Wellwise Members <i>If you're not currently enrolled in Wellwise and want to research the list of coverage medications and plan details for the Wellwise prescription drug benefit, use the following contact information:</i></p> <p>www.optumrx.com User ID: COOTEST1 Password: Orange20</p> <p>Current Members <i>If you have active OptumRx coverage or after your coverage goes into effect, you will use this contact information:</i></p> <p>1-800-573-3583 www.optumrx.com</p>

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 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): 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): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

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

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

Persian (فارسی): یاری کمکتون فایرد ناگیار نابز ی سراف، افطاً مرامشد اب سامت 1-866-346-7198 نفلت دیریگی.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਵਿਰਧਾ ਵਰਵੇ 1-866-346-7198 'ਤੇ ਵਾੱਲ ਵਰਵੇ

Khmer (ខ្មែរ) 1-866-346-7198

Arabic (العربية): لوصول إلى عدعاسملا في فةغلا اناجم تييرعلا، لاصتاب لصفتي لء اذه مقرلا: 1-866-346-7198.

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

Hindi (हिन्दी): 1-866-346-7198

Thai (ไทย): สำหรับ ความช่วยเหลือ ในภาษาไทยโดยไม่มีค ใช้จ่าย โทรไปรตโทร 1-866-346-7198