


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



Coverage Period: 1/1/26 - 12/31/26


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 <u>deductible</u> ?	\$500 per individual / \$1,000 per family for <u>participating providers</u> ; \$750 per individual / \$1,500 per family for <u>non-participating providers</u> .	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. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services listed in your complete terms of coverage.	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 healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$2,500 per individual / \$5,000 per family for <u>participating providers</u> ; \$5,000 per individual / \$10,000 per family for <u>non-participating providers</u> . Prescription Drug: \$4,100 per individual / \$8,200 per family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Medical: <u>Coinsurance</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and penalties for failure to obtain pre-admission review for non-emergency hospitalization. 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 <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See blueshieldca.com/oc or call 1-888-235-1767 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Preventive care/screening</u> /immunization	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<u>Lab & Path</u> : 10% <u>coinsurance</u> <u>X-Ray & Imaging</u> : 10% <u>coinsurance</u> <u>Other Diagnostic Examination</u> : 10% <u>coinsurance</u>	<u>Lab & Path</u> : 30% <u>coinsurance</u> <u>X-Ray & Imaging</u> : 30% <u>coinsurance</u> <u>Other Diagnostic Examination</u> : 30% <u>coinsurance</u>	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	<u>Outpatient Radiology Center</u> : 10% <u>coinsurance</u> <u>Outpatient Hospital</u> : 10% <u>coinsurance</u>	<u>Outpatient Radiology Center</u> : 30% <u>coinsurance</u> <u>Outpatient Hospital</u> : 30% <u>coinsurance</u>	<u>Preauthorization</u> is required for non-emergency Imaging (CT/PET scans, MRIs, etc.) within California. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need drugs to treat your illness or condition	Preventive Drugs (in accordance with Health Care Reform)	0% <u>coinsurance</u>	Not Covered	Your Prescription Drug Coverage is covered by OptumRx. For more information, please call (800) 573-3583.
	Tier 1: Mostly generic drugs	20% <u>coinsurance</u>	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at [bsca.com/policies](https://www.bsca.com/policies).

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	
<p>More information about your prescription drug coverage is available at:</p> <p>Current members: www.optumrx.com</p> <p>Prospective members: https://welcome.optumrx.com/countyoforange</p>	Tier 2: Mostly brand preferred drugs	25% <u>coinsurance</u>	Not Covered	<p>Preauthorization is required for select drugs.</p> <p>Drug Exclusions: The formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available.</p> <p>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. If a member chooses a brand drug when a generic equivalent is available, member will pay the coinsurance for the generic cost plus the full cost differential between generic and brand drug cost, unless the prescriber specifically requests the brand name (dispense as written, do not substitute). The cost differential does not count towards the prescription drug out-of-pocket limit. Manufacturer specialty coupon cards do not count towards the out-of-pocket limit.</p>
	Tier 3: Mostly brand non-preferred drugs	30% <u>coinsurance</u>	Not Covered	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription specialty drug coverage is available at specialty.optumrx.com</p>	Specialty drugs	Percentage indicated up to a maximum of \$150 per 30-day supply	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> 10% <u>coinsurance</u> <i>Outpatient Hospital:</i> 10% <u>coinsurance</u>	<i>Ambulatory Surgery Center:</i> 30% <u>coinsurance</u> <i>Outpatient Hospital:</i> 30% <u>coinsurance</u>	<u>Non-Participating Ambulatory Surgery Center:</u> Up to a maximum of \$1,500 per day.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	<i>Facility Fee:</i> 10% <u>coinsurance</u> <i>Physician Fee:</i> 10% <u>coinsurance</u>	<i>Facility Fee:</i> 10% <u>coinsurance</u> <i>Physician Fee:</i> 10% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	This payment is for emergency or authorized transport. <u>Non-Participating</u> : Member is responsible for all charges above the Usual, Reasonable and Customary (URC) amount for ground ambulance, but only responsible for in-network charges for air ambulance services.
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-admission review required</u> . 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.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Office Visit</u> : 10% <u>coinsurance</u> <u>Other Outpatient Services</u> : 10% <u>coinsurance</u> <u>Partial Hospitalization</u> : 10% <u>coinsurance</u> <u>Psychological Testing</u> : 10% <u>coinsurance</u>	<u>Office Visit</u> : 30% <u>coinsurance</u> <u>Other Outpatient Services</u> : 30% <u>coinsurance</u> <u>Partial Hospitalization</u> : 30% <u>coinsurance</u> <u>Psychological Testing</u> : 30% <u>coinsurance</u>	<u>Preauthorization</u> is required except for office visits and office-based opioid treatment. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Inpatient services	<u>Physician Inpatient Services</u> : 10% <u>coinsurance</u> <u>Hospital Services</u> : 10% <u>coinsurance</u> <u>Residential Care</u> : 10% <u>coinsurance</u>	<u>Physician Inpatient Services</u> : 30% <u>coinsurance</u> <u>Hospital Services</u> : 30% <u>coinsurance</u> <u>Residential Care</u> : 30% <u>coinsurance</u>	<u>Pre-admission review required</u> . Non-Participating: 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% coinsurance.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

* For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<p><u>Preauthorization</u> is required for <u>Non-Participating</u> providers. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.</p> <p>When home health care is authorized as an alternative to continued hospitalization in a Participating Hospital, you will pay 10% coinsurance.</p>
	<u>Rehabilitation services</u>	Office Visit: 10% <u>coinsurance</u> Outpatient Hospital: 10% <u>coinsurance</u>	Office Visit: 30% <u>coinsurance</u> Outpatient Hospital: 30% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	Office Visit: 10% <u>coinsurance</u> Outpatient Hospital: 10% <u>coinsurance</u>	Office Visit: 30% <u>coinsurance</u> Outpatient Hospital: 30% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	Freestanding Skilled Nursing Facility (SNF): 10% <u>coinsurance</u> Hospital-based SNF: 10% <u>coinsurance</u>	Freestanding SNF: 30% <u>coinsurance</u> Hospital-based SNF: 30% <u>coinsurance</u>	<p><u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.</p> <p>Combined maximum of up to 100 days per member per calendar year for semi-private accommodations.</p>
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<p><u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.</p> <p>When hospice residence immediately follows inpatient services in a Participating Hospital, you will pay 10% coinsurance for hospice services.</p>
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Covered under Preventive Services
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

* For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies.

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

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Bariatric surgery
- Continuous glucose monitors
- 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 1-877-267-2323 x61565 or cciio.cms.gov. 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/ebsa/healthreform.

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

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

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 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): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

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

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ອຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ 1-866-346-7198.

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 <u>deductible</u>	\$500
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,770

Managing Joe's Type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,100

Mia's Simple Fracture

(participating emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$710

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

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NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with 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 (large print, audio, accessible electronic formats, other formats)
- 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, the 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.