Sharewell Retiree PPO Health Plan - 2026

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%.	**Combined Medical and Pharmacy** Network: $6,000 Family Non-Network: $12,000 Family ***Non-Network Out-of-Pocket Maximum does not include** the costs of services not covered; amounts in excess of the Usual, Reasonable and Customary (URC) amount; 20% coinsurance for failure to obtain pre-admission approval for inpatient care, or permissible balance billing charges. 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 Health Services and Drugs As set forth in Plan Document	No coinsurance and no deductible
Primary Care and Specialist Physician Office Visits, Laboratory Services, Urgent Care Facility, Rehabilitative Therapy, and Outpatient Surgery-Hospital	Network: 10% coinsurance Non-Network: 30% coinsurance
Medical - Inpatient Hospital Services	Network: 10% coinsurance Non-Network: 30% coinsurance; without pre-admission review, 50% coinsurance
Outpatient Surgery - Ambulatory Surgery Center (facility charges)	Network: 10% coinsurance Non-Network: Plan pays 70% up to $1,500/ day; member pays balance
Emergency Room Treatment Based on Plan Document "Emergency Services" definition	Network/Non-Network: 10% coinsurance
Mental Health and Substance Abuse - Inpatient Services	Network: 10% coinsurance Non-Network: 30% coinsurance; without pre-admission review, 50% coinsurance
Mental Health and Substance Abuse - Outpatient Services	Network: 10% coinsurance Non-Network: 30% coinsurance
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% coinsurance Non-Network: 30% coinsurance

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% coinsurance Non-Network 30% coinsurance
Durable Medical Equipment As set forth in the Plan Document	Network: 10% coinsurance Non-Network: 30% coinsurance
Hearing Aids	$5,000 per member; within any thirty-six month period
Dialysis Services (Outpatient)	Network: 10% coinsurance Non-Network (within CA): Plan pays 70% up to $600/day; member pays balance Non-Network (outside CA): 30% coinsurance
Home Health Care and Hospice Services Prior authorization required for Non-Network provider.	Network: 10% coinsurance Non-Network: 30% coinsurance
Skilled Nursing and Rehabilitation Facility Prior authorization required for Non-Network provider. 100 days per Calendar Year limit (combined Network/Non-Network)	Network: 10% coinsurance Non-Network: 30% coinsurance
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.	Network: 10% coinsurance Non-Network: Not covered

Prescription Drug Coverage	
Preventive Products	0% coinsurance
Generic, brand name and specialty pharmacy drugs	20% coinsurance
Prescription drugs are subject to the plan deductible.	*IMPORTANT CONSIDERATIONS:
The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered medication available.	When a generic drug option is available, and the member chooses a brand-name drug, the member pays the full cost differential between the generic and brand-name cost plus the coinsurance for the generic, unless their prescriber specifically requests the brand-name (dispense as written or do not substitute) on the prescription. All Specialty Drugs must be fulfilled by Pharmacy Benefits Manager's Specialty Pharmacy in order to be covered, unless otherwise required by law. If a Participant utilizes a manufacturer coupon, the amount covered by the coupon will not be applied towards their deductible and annual 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://welcome.optumrx.com/countyoforange/landing ***Optum Specialty Pharmacy:*** 1-855-427-4682 specialty.optumrx.com

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, ancestry, religion, sex, marital status, pregnancy or related conditions, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientations, age, or disability.

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 Blue Shield of California Customer Services using the number on the back of your member ID card.

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, ancestry, religion, sex, marital status, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientations, age, or disability, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 5588, El Dorado Hills, CA 95762-0011
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
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://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.

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, kwiįį' 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): 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 ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

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

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

Laotian (ພາສາລາວ): ສຳລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.