blue of california

Summary of Benefits

PRISM/Santa Barbara Superior Courts
Effective January 1, 2024
EPO Plan

ASO EPO Retiree Plan

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. This is an Exclusive Provider Organization (EPO) plan. You must receive all Covered Services from a Participating Provider, but there are some exceptions. Please review your Benefit Booklet for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]
Individual coverage	$1,500
Family coverage	$1,500: individual
	$3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Preventive Health Services[6]		
Preventive Health Services	$0	
Physician services		
Primary care office visit	$20/visit	
Specialist care office visit	$20/visit	
Physician home visit	$50/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$20/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Acupuncture services	$20/visit	
Up to 12 visits per Member, per Calendar Year. Plan payment maximum of $50/visit.		
Chiropractic services	$20/visit	
Up to 30 visits per Member, per Calendar Year.		
Teladoc consultation	$20/consult	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive	$0	
• Diaphragm fitting	$0	
• Intrauterine device (IUD)	$0	
• Insertion and/or removal of intrauterine device (IUD)	$0	
• Implantable contraceptive	$0	
• Tubal ligation	$0	
• Vasectomy	$75/surgery	
• Diagnosis and Treatment of the Cause of Infertility	50%	
Podiatric services	$20/visit	
Medical nutrition therapy, not related to diabetes	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$100/visit	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Emergency Services		
Emergency room services	$100/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room Physician services	$0	
Urgent care center services	$20/visit	
Ambulance services	$50/transport	
This payment is for emergency or authorized transport.		
Outpatient Facility services		
Ambulatory Surgery Center	$0	
Outpatient Department of a Hospital: surgery	$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$250/admission plus 20%	
Transplant services		
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.		
• Special transplant facility inpatient services	$250/admission plus 20%	
• Physician inpatient services	$0	
Bariatric surgery services		
Inpatient facility services	$250/admission plus 20%	
Outpatient Facility services	$0	
Physician services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services		
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory and pathology services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
• Outpatient Department of a Hospital	$0	
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$0	
• Outpatient Department of a Hospital	$0	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Speech Therapy services		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	20%	
Prosthetic equipment and devices	20%	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	20%	
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%	
Hemophilia home infusion services *Includes blood factor products.*	20%	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*		
Freestanding SNF	20%	
Hospital-based SNF	20%	
Hospice program services		
Pre-Hospice consultation	$0	
Routine home care	$0	
24-hour continuous home care	20%	
Short-term inpatient care for pain and symptom management	20%	
Inpatient respite care	$0	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$20/visit	
• Medical nutrition therapy	$20/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	$0	
Hearing aid services		
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24-month period.*	$0	

Mental Health and Substance Use Disorder Benefits

	Your payment When using a Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc mental health	$20/consult	
Intensive outpatient care	$0	
Behavioral Health Treatment in an office setting	$0	
Behavioral Health Treatment in home or other non-institutional setting	$0	
Office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$250/admission plus 20%	
Residential Care	$250/admission plus 20%	

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Notes

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowable Amount, and charges for services above any Benefit maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with Federal requirements.

lg081623