blue of california

Summary of Benefits

PRISM/Santa Barbara Superior Courts
Effective January 1, 2026
PPO Savings Plan

ASO HDHP Aggregate Deductible/Embedded Out of Pocket Maximum 1700/3400

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. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. 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 the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$1,700
	Family coverage	$3,400

Calendar Year Out-of-Pocket Maximum[5]

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 any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$4,500
Family coverage	$4,500: individual $9,000: 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.

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Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		40%	✔
Physician services				
Primary care office visit	20%	✔	40%	✔
Specialist care office visit	20%	✔	40%	✔
Physician home visit	20%	✔	Not covered	
Physician or surgeon services in an Outpatient Facility	20%	✔	40%	✔
Physician or surgeon services in an inpatient facility	20%	✔	40%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	20%	✔	40%	✔
Acupuncture services *Up to 12 visits per Member, per Calendar Year.*	$20/visit Subject to a Benefit maximum of $50/visit	✔	$20/visit Subject to a Benefit maximum of $50/visit	✔
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	20%	✔	40%	✔
Teladoc Health consultation	$40/consult	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		40%	✔
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		40%	✔
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		40%	✔
• Vasectomy	20%	✔	40%	✔
Podiatric services	20%	✔	40%	✔
Medical nutrition therapy, not related to diabetes	20%	✔	40%	✔
Diagnosis and Treatment of the Cause of Infertility	50%	✔	Not covered	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Physician services for pregnancy termination	20%	✔	40%	✔
Emergency Services				
Emergency room services *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.*	20%	✔	20%	✔
Emergency room Physician services	20%	✔	20%	✔
Urgent care center services	20%	✔	40%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
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	20%	✔	Not covered	
• Physician inpatient services	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.				
Inpatient facility services	20%	✔	Not covered	
Outpatient Facility services	20%	✔	Not covered	
Physician services	20%	✔	Not covered	
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	✔	40%	✔
• Outpatient Department of a Hospital	$0	✔	40% Subject to a Benefit maximum of $350/day	✔
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	$0	✔	40%	✔
• Outpatient Department of a Hospital	$0	✔	40% Subject to a Benefit maximum of $350/day	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	✔	40%	✔
• Outpatient Department of a Hospital	$0	✔	40% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	40% Subject to a Benefit maximum of $800/visit	✔
• Outpatient Department of a Hospital	$0	✔	40% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	20%	✔	Not covered	
Outpatient Department of a Hospital	20%	✔	Not covered	
Speech Therapy services				
Office location	20%	✔	40%	✔
Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	20%	✔	40%	✔
Breast pump	$0		Not covered	
Glucose monitor	$0		40%	✔
Peak Flow Meter	$0		40%	✔
Orthotic equipment and devices	20%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Prosthetic equipment and devices	20%	✔	40%	✔
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%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	Not covered	
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%	✔	20%	✔
Hospital-based SNF	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	$0	✔	Not covered	
Routine home care	$0	✔	Not covered	
24-hour continuous home care	20%	✔	Not covered	
Short-term inpatient care for pain and symptom management	20%	✔	Not covered	
Inpatient respite care	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	40%	✔
• Self-management training	20%	✔	40%	✔
• Medical nutrition therapy	20%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Dialysis services	20%	✔	40% Subject to a Benefit maximum of $300/day	✔
PKU product formulas and special food products	20%	✔	Not covered	
Allergy serum billed separately from an office visit	20%	✔	40%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $700 combined maximum per Member, per 24-month period.*	20%	✔	20%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	20%	✔	40%	✔
Teladoc Health mental health	$40/consult	✔	Not covered	
Intensive outpatient care	20%	✔	40%	✔
Behavioral Health Treatment in an office setting	20%	✔	40%	✔
Behavioral Health Treatment in home or other non-institutional setting	20%	✔	40%	✔
Office-based opioid treatment	20%	✔	40%	✔
Partial Hospitalization Program	$0	✔	40% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	40%	✔
Inpatient services				
Physician inpatient services	20%	✔	40%	✔
Hospital services	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
Residential Care	20%	✔	40% Subject to a Benefit maximum of $600/day	✔

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.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible. For Family Coverage. The Family Deductible must be met by you and your Family members collectively within a Calendar Year.

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.

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

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

Notes

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Deductible or Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 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 and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a combined Participating Provider and Non-Participating Provider OOPM.

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.

6 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.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a Participating Provider. 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.