



Summary of Benefits

PRISM/ County of San Luis Obispo
Effective January 1, 2026
PPO Plan

Blue Shield Medicare PPO 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. 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.

		When using a Participating ³ or Non-Participating ⁴ Provider
Calendar Year medical Deductible	Individual coverage	\$0
	Family coverage	\$0: individual
		\$0: Family

Calendar Year Out-of-Pocket Maximum⁵

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	\$0
Family coverage	\$0: individual
	\$0: 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.

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		\$0	
Physician services				
Primary care office visit	\$0		\$0	
Specialist care office visit	\$0		\$0	
Physician home visit	\$0		\$0	
Physician or surgeon services in an Outpatient Facility	\$0		\$0	
Physician or surgeon services in an inpatient facility	\$0		\$0	
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$0		\$0	
Acupuncture services <i>Combined with chiropractic services, up to 20 visits per Member, per Calendar Year.</i>	\$15/visit		\$15/visit	
Chiropractic services <i>Combined with acupuncture services, up to 20 visits per Member, per Calendar Year.</i>	\$0		\$0	
Family planning				
• Counseling, consulting, and education	\$0		\$0	
• Injectable contraceptive	\$0		\$0	
• Diaphragm fitting	\$0		\$0	
• Intrauterine device (IUD)	\$0		\$0	
• Insertion and/or removal of intrauterine device (IUD)	\$0		\$0	
• Implantable contraceptive	\$0		\$0	
• Tubal ligation	\$0		\$0	
• Vasectomy	\$0		\$0	
Podiatric services	\$0		\$0	
Medical nutrition therapy, not related to diabetes	\$0		\$0	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	\$0		\$0	
Physician services for pregnancy termination	\$0		\$0	

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Emergency Services				
Emergency room services	\$0		\$0	
<i>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.</i>				
Emergency room Physician services	\$0		\$0	
Urgent care center services	\$0		\$0	
Ambulance services	\$0		\$0	
<i>This payment is for emergency or authorized transport.</i>				
Outpatient Facility services				
Ambulatory Surgery Center	\$0		\$0	
Outpatient Department of a Hospital: surgery	\$0		\$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0		\$0	
Inpatient facility services				
Hospital services and stay	\$0		\$0	
Transplant services				
<i>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.</i>				
• Special transplant facility inpatient services	\$0		Not covered	
• Physician inpatient services	\$0		Not covered	
Bariatric surgery services				
Inpatient facility services	\$0		\$0	
Outpatient Facility services	\$0		\$0	
Physician services	\$0		\$0	

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Diagnostic x-ray, imaging, pathology, and laboratory services				
<i>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.</i>				
Laboratory and pathology services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	\$0		\$0	
• Outpatient Department of a Hospital	\$0		\$0	
Basic imaging services				
<i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>				
• Outpatient radiology center	\$0		\$0	
• Outpatient Department of a Hospital	\$0		\$0	
Other outpatient non-invasive diagnostic testing				
<i>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.</i>				
• Office location	\$0		\$0	
• Outpatient Department of a Hospital	\$0		\$0	
Advanced imaging services				
<i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>				
• Outpatient radiology center	\$0		\$0	
• Outpatient Department of a Hospital	\$0		\$0	
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>				
Office location	\$0		\$0	
Outpatient Department of a Hospital	\$0		\$0	
Speech Therapy services				
Office location	\$0		\$0	
Outpatient Department of a Hospital	\$0		\$0	

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Durable medical equipment (DME)				
DME	\$0		\$0	
Breast pump	\$0		\$0	
Orthotic equipment and devices	\$0		\$0	
Prosthetic equipment and devices	\$0		\$0	
Home health care services	\$0		\$0	
Home infusion and home injectable therapy services				
Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>	\$0		\$0	
Hemophilia home infusion services <i>Includes blood factor products.</i>	\$0		\$0	
Skilled Nursing Facility (SNF) services				
Freestanding SNF	\$0		\$0	
Hospital-based SNF	\$0		\$0	
Hospice program services				
Pre-Hospice consultation	\$0		\$0	
Routine home care	\$0		\$0	
24-hour continuous home care	\$0		\$0	
Short-term inpatient care for pain and symptom management	\$0		\$0	
Inpatient respite care	\$0		\$0	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	\$0		\$0	
• Self-management training	\$0		\$0	
• Medical nutrition therapy	\$0		\$0	
Dialysis services	\$0		\$0	
PKU product formulas and special food products	\$0		\$0	
Allergy serum billed separately from an office visit	\$0		\$0	
Hearing aid services				
• Hearing aids and equipment <i>Up to \$2,000 combined maximum per Member, per 24-month period.</i>	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	\$0		\$0	
Intensive outpatient care	\$0		\$0	
Behavioral Health Treatment in an office setting	\$0		\$0	
Behavioral Health Treatment in home or other non-institutional setting	\$0		\$0	
Office-based opioid treatment	\$0		\$0	
Partial Hospitalization Program	\$0		\$0	
Psychological Testing	\$0		\$0	
Inpatient services				
Physician inpatient services	\$0		\$0	
Hospital services	\$0		\$0	
Residential Care	\$0		\$0	

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.

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.

"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 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.

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. 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.