blue of california

Summary of Benefits

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

Blue Shield Tandem 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: Tandem PPO Network

This Plan uses a specific network of Health Care Providers, called the Tandem 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*	$1,250
	Family coverage	$1,250: individual $2,500: Family

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 a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$3,000	None
Family coverage	$3,000: individual $6,000: Family	None: individual None: 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[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	$35/visit		40%	✔
Specialist care office visit	$35/visit		40%	✔
Physician home visit	$35/visit		40%	✔
Physician or surgeon services in an Outpatient Facility	25%	✔	40%	✔
Physician or surgeon services in an inpatient facility	25%	✔	40%	✔
Other professional services				
Other practitioner office visit	$35/visit		40%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$15/visit		40%	✔
Combined with chiropractic services, up to 20 visits per Member, per Calendar Year.				
Chiropractic services	$15/visit		40%	✔
Combined with acupuncture services, up to 20 visits per Member, per Calendar Year.				
Family planning				
• Counseling, consulting, and education	$0		40%	✔
• Injectable contraceptive	$0		40%	✔
• Diaphragm fitting	$0		40%	✔
• Intrauterine device (IUD)	$0		40%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		40%	✔
• Implantable contraceptive	$0		40%	✔
• Tubal ligation	$0		40%	✔
• Vasectomy	25%	✔	40%	✔
Podiatric services	$35/visit		40%	✔
Medical nutrition therapy, not related to diabetes	25%	✔	40%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$35/visit		40%	✔
Physician services for pregnancy termination	25%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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.*	$100/visit plus 25%	✔	$100/visit plus 25%	✔
Emergency room Physician services	25%	✔	25%	✔
Urgent care center services	$35/visit		40%	✔
Ambulance services *This payment is for emergency or authorized transport.*	25%	✔	25%	✔
Outpatient Facility services				
Ambulatory Surgery Center	25%	✔	40%	✔
Outpatient Department of a Hospital: surgery	25%	✔	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	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	25%	✔	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	25%	✔	Not covered	
• Physician inpatient services	25%	✔	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	25%	✔	Not covered	
Outpatient Facility services	25%	✔	Not covered	
Physician services	25%	✔	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	25%	✔	40%	✔
• Outpatient Department of a Hospital	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	25%	✔	40%	✔
• Outpatient Department of a Hospital	25%	✔	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	25%	✔	40%	✔
• Outpatient Department of a Hospital	25%	✔	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	25%	✔	40%	✔
• Outpatient Department of a Hospital	25%	✔	40% Subject to a Benefit maximum of $800/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.* *Up to 30 visits per Member, per Calendar Year.*				
Office location	25%	✔	40%	✔
Outpatient Department of a Hospital	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
Speech Therapy services *Up to 24 visits per Member, per Calendar Year.*				
Office location	25%	✔	40%	✔
Outpatient Department of a Hospital	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	25%	✔	40%	✔
Breast pump	$0		40%	✔
Orthotic equipment and devices	25%	✔	40%	✔
Prosthetic equipment and devices	25%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health care services *Up to 45 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.*	25%	✔	40%	✔
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	25%	✔	40%	✔
Hemophilia home infusion services *Includes blood factor products.*	25%	✔	40%	✔
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	25% for the first 10 days, then 30% thereafter	✔	40%	✔
Hospital-based SNF	25% for the first 10 days, then 30% thereafter	✔	40% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	25%	✔	25%	✔
Routine home care	25%	✔	25%	✔
24-hour continuous home care	25%	✔	25%	✔
Short-term inpatient care for pain and symptom management	25%	✔	25%	✔
Inpatient respite care	25%	✔	25%	✔
Other services and supplies				
Christian Science services • Nursing services *Up to 24 visits per Calendar Year.*	25%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Diabetes care services				
• Devices, equipment, and supplies	25%	✔	40%	✔
• Self-management training	$35/visit		40%	✔
• Medical nutrition therapy	$35/visit		40%	✔
Dialysis services	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	25%	✔	25%	✔
Allergy serum billed separately from an office visit	25%	✔	40%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $1,000 combined maximum per Member, per 36-month period.*	25%	✔	25%	✔

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	$35/visit		40%	✔
Intensive outpatient care	25%	✔	40%	✔
Behavioral Health Treatment in an office setting	25%	✔	40%	✔
Behavioral Health Treatment in home or other non-institutional setting	25%	✔	40%	✔
Office-based opioid treatment	25%	✔	40%	✔
Partial Hospitalization Program	25%	✔	40% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	25%	✔	40%	✔
Inpatient services				
Physician inpatient services	25%	✔	40%	✔
Hospital services	25%	✔	40% Subject to a Benefit maximum of $600/day	✔

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
Residential Care	25%	✔	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.

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

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.

"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 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 separate Participating Provider OOPM 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.

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