blue of california

PRISM/El Dorado County
Effective January 1, 2021
PPO Savings Plan

Summary of Benefits

HDHP 1400/2800

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.

Medical 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.

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Plus Formulary**

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. 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 and pharmacy Deductible	*Individual coverage*	$1,400
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family coverage*	$2,800: individual $2,800: 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	$2,500	$5,000
Family coverage	$2,800: individual $5,000: Family	$5,000: individual $6,000: 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[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		50%	✔
Physician services				
Primary care office visit	30%	✔	50%	✔
Specialist care office visit	30%	✔	50%	✔
Office visit for allergy injection	30%	✔	50%	✔
Physician home visit	30%	✔	50%	✔
Physician or surgeon services in an outpatient facility	30%	✔	50%	✔
Physician or surgeon services in an inpatient facility	30%	✔	50%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	30%	✔	50%	✔
Acupuncture services	30%	✔	30%	✔
Chiropractic services *Up to 30 visits per Member, per Calendar Year.*	$10/visit	✔	50% of up to $30/member /visit plus 100% of additional charges	✔
Teladoc consultation	$40/consult	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		50%	✔
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		50%	✔
• 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		50%	✔
• Vasectomy	20%	✔	50%	✔
Podiatric services	30%	✔	50%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✔	50%	✔
Physician services for pregnancy termination	20%	✔	50%	✔

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.*	$50/visit plus 20%	✔	$50/visit plus 20%	✔
Emergency room Physician services	20%	✔	20%	✔
Urgent care center services	30%	✔	50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient facility services				
Ambulatory Surgery Center	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	20%	✔	50% of up to $600/day plus 100% of additional charges	✔
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	30%	✔	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
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, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	20%	✔	50%	✔
• Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	20%	✔	50%	✔
• Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	50% of up to $800/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.*				
Office location	20%	✔	50%	✔
Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Speech Therapy services				
Office location	20%	✔	50%	✔
Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	20%	✔	50%	✔
Breast pump	$0		50%	✔
Orthotic equipment and devices	20%	✔	50%	✔
Prosthetic equipment and devices	20%	✔	50%	✔
Home health care services *Up to 120 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 and medical supplies.*	20%	✔	Not covered	
Home visits by an infusion nurse	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
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 120 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%	✔	50% of up to $600/day plus 100% of additional charges	✔
Hospice program services				
Pre-Hospice consultation	20%	✔	Not covered	
Routine home care	20%	✔	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	20%	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	50%	✔
• Self-management training	20%	✔	50%	✔
Dialysis services	20%	✔	50% of up to $300/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum billed separately from an office visit	30%	✔	50%	✔
Hearing services				
• Hearing aids and equipment *Up to $1,200 combined maximum per Member, per 24-month.*	20%	✔	20%	✔
• Audiological evaluations	20%	✔	50%	✔
Learning impairment evaluation tests	20%	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Up to $200 combined maximum per Member, per lifetime.				

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%	✔	50%	✔
Teladoc behavioral health	$40/consult	✔	Not covered	
Intensive outpatient care	20%	✔	50%	✔
Behavioral Health Treatment in an office setting	20%	✔	50%	✔
Behavioral Health Treatment in home or other non-institutional setting	20%	✔	50%	✔
Office-based opioid treatment	20%	✔	50%	✔
Partial Hospitalization Program	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	50%	✔
Inpatient services				
Physician inpatient services	20%	✔	50%	✔
Hospital services	20%	✔	50% of up to $600/day plus 100% of additional charges	✔
Residential Care	20%	✔	50% of up to $600/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	Your payment			
	When using a Participating Pharmacy[3]	CYD[2] applies	When using a Non-Participating Pharmacy[4]	CYD[2] applies
Retail pharmacy prescription Drugs *Per prescription, up to a 30-day supply.*				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$10/prescription	✔	$10/prescription	✔
Tier 2 Drugs	$15/prescription	✔	$15/prescription	✔
Tier 3 Drugs	$30/prescription	✔	$30/prescription	✔
Tier 4 Drugs	30% up to $125/prescription	✔	30% up to $125/prescription	✔
Mail service pharmacy prescription Drugs *Per prescription, up to a 90-day supply.*				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$10/prescription	✔	Not covered	
Tier 2 Drugs	$15/prescription	✔	Not covered	
Tier 3 Drugs	$30/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $250/prescription	✔	Not covered	
Oral Anticancer Drugs *Per prescription, up to a 30-day supply.*	Applicable Tier 1, Tier 2, Tier 3, or Tier 4 Copayment up to $125/prescription	✔	Not covered	

Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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

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. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

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 (behavioral health) 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.

Notes

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, or
- any charges above the stated dollar amount, which is the Benefit maximum.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum 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, charges above the Allowable Amount, and charges for services above any Benefit maximum.

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

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM. Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the 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 Copayment in addition to an allergy serum Copayment 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.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

Notes

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Claims Administrator for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

High Deductible Health Plan (HDHP) preventive Drugs. HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit blueshieldca.com/pharmacy for lists of these Drugs.

Plans may be modified to ensure compliance with Federal requirements.

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