



Summary of Benefits

Advantage Sales and Marketing
HPN, LLC
Effective January 1, 2023
EPO Plan

Blue Shield High Performance HPN CDHP

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: Blue High Performance Network

This Plan uses a specific network of Health Care Providers, called the Blue High Performance 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. 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 Provider ³		
Calendar Year medical Deductible	Individual coverage	\$2,500
	Family coverage	\$5,000

Calendar Year Out-of-Pocket Maximum⁴

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	\$5,000
Family coverage	\$5,000: individual \$10,000: 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.

Benefits⁵

Your payment

	When using a Participating Provider ³	CYD ² applies
Preventive Health Services⁶		
Preventive Health Services	\$0	
Physician services		
Primary care office visit	20%	✓
Specialist care office visit	20%	✓
Physician home visit	20%	✓
Physician or surgeon services in an Outpatient Facility	20%	✓
Physician or surgeon services in an inpatient facility	20%	✓
Other professional services		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	20%	✓
Acupuncture services <i>Up to 12 visits per Member, per Calendar Year.</i>	20%	✓
Chiropractic services	20%	✓
Teladoc consultation	20%	✓
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	20%	✓
• Diagnosis and Treatment of the Cause of Infertility	20%	✓
Podiatric services	20%	✓
Medical nutrition therapy, not related to diabetes	20%	✓
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	20%	✓
Physician services for pregnancy termination	20%	✓

	When using a Participating Provider ³	CYD ² applies
Emergency Services		
Emergency room services	20%	✓
<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	20%	✓
Urgent care center services (freestanding)	20%	✓
Ambulance services	20%	✓
<i>This payment is for emergency or authorized transport.</i>		
Outpatient Facility services		
Ambulatory Surgery Center	20%	✓
Outpatient Department of a Hospital: surgery	20%	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓
Inpatient facility services		
Hospital services and stay	20%	✓
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	20%	✓
• Physician inpatient services	20%	✓
Bariatric surgery services, designated California counties		
<i>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.</i>		
Inpatient facility services	20%	✓
Outpatient Facility services	20%	✓
Physician services	20%	✓

	When using a Participating Provider ³	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, 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.</i>		
Laboratory services		
<i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	20%	✓
• Outpatient Department of a Hospital	20%	✓
X-ray and imaging services		
<i>Includes diagnostic mammography.</i>		
• Outpatient radiology center	20%	✓
• Outpatient Department of a Hospital	20%	✓
Other outpatient diagnostic testing		
<i>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.</i>		
• Office location	20%	✓
• Outpatient Department of a Hospital	20%	✓
Radiological and nuclear imaging services		
• Outpatient radiology center	20%	✓
• Outpatient Department of a Hospital	20%	✓
Rehabilitative and Habilitative Services		
<i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>		
Office location	20%	✓
Outpatient Department of a Hospital	20%	✓
Speech Therapy services		
Office location	20%	✓
Outpatient Department of a Hospital	20%	✓
Durable medical equipment (DME)		
DME	20%	✓
Breast pump	\$0	
Orthotic equipment and devices	20%	✓
Prosthetic equipment and devices	20%	✓

	When using a Participating Provider ³	CYD ² applies
Home health care services <i>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.</i>	20%	✓
Home infusion and home injectable therapy services Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>	20%	✓
Hemophilia home infusion services <i>Includes blood factor products.</i>	20%	✓
Skilled Nursing Facility (SNF) services <i>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.</i>		
Freestanding SNF	20%	✓
Hospital-based SNF	20%	✓
Hospice program services Pre-Hospice consultation Routine home care 24-hour continuous home care Short-term inpatient care for pain and symptom management Inpatient respite care	20% 20% 20% 20% 20%	✓ ✓ ✓ ✓ ✓
Other services and supplies Diabetes care services <ul style="list-style-type: none"> Devices, equipment, and supplies Self-management training Medical nutrition therapy Dialysis services PKU product formulas and special food products Allergy serum billed separately from an office visit Hearing aid services <ul style="list-style-type: none"> Hearing aids and equipment <i>2 hearing aids per member per 36 months.</i> Wigs (after chemotherapy)	20% 20% 20% 20% 20% 20% 20%	✓ ✓ ✓ ✓ ✓ ✓ ✓

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%	✓
Teladoc mental health	20%	✓
Intensive outpatient care	20%	✓
Behavioral Health Treatment in an office setting	20%	✓
Behavioral Health Treatment in home or other non-institutional setting	20%	✓
Office-based opioid treatment	20%	✓
Partial Hospitalization Program	20%	✓
Psychological Testing	20%	✓
Inpatient services		
Physician inpatient services	20%	✓
Hospital services	20%	✓
Residential Care	20%	✓

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 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

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.

For Family Coverage. The Family Deductible must be met by you and your Family members collectively within a Calendar Year.

3 Using Participating Providers:

All Benefits must be provided by Participating (Preferred) Providers in the Blue High Performance Network (HPN), except in emergency situations when accessing care from non-HPN providers within HPN product areas and urgent/emergent care outside of HPN product areas.

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.

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

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