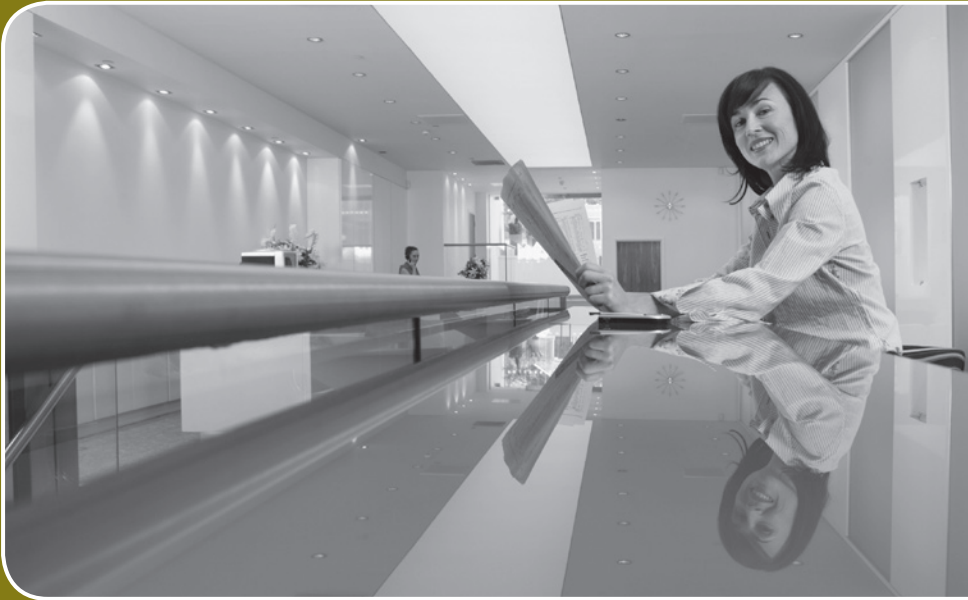


ProtectPlus Healthcare Plan 2012



CalCPA
ProtectPlus
Healthcare just for CPAs



Protect **HSA** 3500

Benefit Highlights

Your healthcare needs are important, both to you, the employee—and to your employer. This brochure highlights your benefits under the CalCPA endorsed **Protect HSA \$3,500 healthcare plan.**

Changes Related to Prescription Drugs

Effective January 1, 2012, the pharmacy benefit manager for the ProtectPlus Copay and HSA-eligible medical plans changed from Express Scripts Inc. to Medco. Medco is the highest ranked independent pharmacy benefit manager on Fortune 50 and has been named Fortune Magazine's "Worlds Most Admired" in its industry class for 4 consecutive years.

ProtectPlus Works for You

Thank you for choosing CalCPA ProtectPlus, the only healthcare plan designed by CPAs strictly for CPAs and their employees. As a ProtectPlus participant, you will enjoy reliable, comprehensive coverage and the power to choose the California doctors and hospitals you prefer.

You now have access to the Anthem Blue Cross provider network, with more than 58,100 participating doctors, and more than 490 hospitals and clinics across California. ProtectPlus lets you use either in-network or out-of-network providers, and gives you the flexibility to use any combination of doctors, hospitals and other healthcare providers.

Three out of four eligible physicians in California participate in the network, so you'll have the freedom to choose virtually any healthcare provider. And by choosing network providers, you get the benefit of negotiated rates with lower out-of-pocket expenses. Visit cpaprotectplus.com to view a complete list of doctors and hospitals. The Summary of Benefits chart that details key features of the plan you've chosen can be found on page 4.

ProtectPlus Features Include:

- Cost Savings
- Freedom of Choice
- Higher Benefit Levels
- Simplified Procedures
- Access to Quality Care
- Comprehensive Coverage
- Emergency Care Coverage
- Customer Service Dedicated to ProtectPlus Members
- Rights of Survivorship

Disclaimer

This brochure is not a contract. Please refer to your plan's Medical Plan Document and Disclosure Form or Certificate. In the event of any conflicts between the information in this brochure and the official plan document, the plan document will govern.

What is Protect HSA

Protect HSA \$3,500 is a self-funded High Deductible Healthcare Plan (HDHP) offered through the Group Insurance Trust of the California Society of CPAs. It is designed to meet the Health Savings Account (HSA) requirements set forth in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Protect HSA \$3,500, when paired with a Health Savings Account offered through a bank, brokerage or other financial institution, provides security against catastrophic medical expenses, while allowing you to set aside and accumulate pre-tax dollars in an HSA to pay for qualified medical expenses.

Health Savings Accounts — Bank of New York Mellon, US Bank and Alliant Credit Union

You may pair CalCPA ProtectPlus HSA Plans with a Health Savings Account offered (where available) through the financial institution of your choice. However, as a member service the Trust has made access to Health Savings Accounts through Bank of New York Mellon, US Bank and Alliant Credit Union available to ProtectPlus HSA subscribers. For your convenience, shortly after confirming your enrollment in a ProtectPlus HSA Plan, you will be provided with a “Welcome Kit” which includes HSA enrollment materials for the HSA provider you have selected.

For more information regarding HSA accounts through Bank of New York Mellon visit www.HSAmember.com, through US Bank visit www.myhsa.usbank.com, or through Alliant Credit Union visit www.alliantcreditunion.org.

Employee Eligibility

To be eligible for coverage as an employee, you must be employed on a permanent basis and work at least 20 hours per week (or 30 if elected by your employer). In circumstances where a spouse is the only full-time employee of a licensed member, the firm may be required to provide a copy of the spouse's most recent W-2 form to verify the employment relationship.

If you are a new hire, you must complete an Employee Enrollment Form and return it to the plan's administrator, Banyan Administrators, LLC, within 31 days of becoming eligible for coverage.

If you are a late enrollee, you will be medically underwritten and may be required to complete a 12-month waiting period from the date on your initial enrollment form before becoming eligible to participate in the plan.

Dependent Eligibility

Eligible dependents of covered employees include:

- The legal spouse
- Dependent children through age 25
- Disabled, dependent children who, with appropriate medical certification, are eligible for coverage at any age
- Domestic partners:
 - Opposite-sex partners who complete and meet criteria set forth in an affidavit of domestic partnership
 - Same-sex partners who are registered as domestic partners with the State of California
- Dependent children of an eligible domestic partner through age 25

Summary of Benefits Protect HSA \$3,500

This chart summarizes some of the major benefits offered under the CalCPA Protect HSA \$3,500 Plan option. Benefits listed are per member costs, subject to deductibles unless otherwise stated.

Benefit Description	In-Network	Out-of-Network
Annual Deductible	\$3,500 per member* \$7,000 per family** (Combined in/out-of-network deductibles)	
Annual Out-of-Pocket Maximum	\$5,500 per member* \$11,000 family** (Combined in/out-of-network out of pocket maximum)	
Lifetime Maximum Benefit	None (\$2,000,000 calendar year maximum)	
Office Visits	20% of negotiated fee after deductible	Plan pays 50% of allowable fee after deductible
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	20% of negotiated fee after deductible	Plan pays 50% of allowable fee after deductible
Inpatient Services (overnight hospital/facility stays)	20% of negotiated fee after deductible	Plan pays 50% of allowable fee up to \$540 per day, after deductible
Outpatient Services (without overnight hospital/facility stays)	20% of negotiated fee after deductible	Plan pays 50% of allowable fee after deductible
Ambulatory Surgical Center	20% of negotiated fee after deductible	Plan pays 50% of allowable fee up to \$350 per visit, after deductible
Emergency Care (non-hospital)	20% of negotiated fee after deductible	Plan pays 70% of allowable fee after deductible
Physical Therapy, Occupational Therapy, Chiropractic Care (Up to 25 visits per year)	20% of negotiated fee after deductible	Plan pays 50% of allowable fee after deductible, up to \$40 per visit
Preventive Care (Ages 7 and Up) (One physical per year)	Not subject to the deductible, 100% plan paid	Plan pays 50% of allowable fee after deductible
Well-Woman (One visit per year)	Not subject to the deductible, 100% plan paid	Plan pays 50% of allowable fee after deductible
Well-Baby Care	Not subject to the deductible, 100% plan paid	Plan pays 50% of allowable fee after deductible
Prescription Drugs Annual Deductible (Combines in/out-of-network charges) <small>Note: Some Specialty Drugs are only available through Medco's Accredo mail order program</small>	No separate deductible	
Retail Pharmacies (30-day supply)	20% of negotiated drug fee after deductible	Plan pays 50% of the allowable drug fee after deductible. Member pays any excess charges.
Mail Order (60-day supply) (Medco mail order pharmacy only)	20% of negotiated drug fee after deductible	Not covered
Self-Administered Injectable Drugs (excluding insulin)	30% of negotiated drug fee after deductible	Not covered

Mental Health & Substance Abuse Benefits

Benefits	In-Network	Out-of-Network
Inpatient Services (overnight hospital/facility stays)	20% of negotiated fee after deductible	Plan pays 50% of allowable fee, up to a max. of \$540 per day
Outpatient Services (without overnight hospital/facility stays)	20% of negotiated fee after deductible	Plan pays 50% of negotiated fee after deductible
Office Visits/Therapy Sessions	20% of negotiated fee after deductible	Plan pays 50% of negotiated fee after deductible

***Individual Coverage**

Individual Coverage refers to a subscriber without covered dependents. Individual subscribers are subject to the Individual Deductible and Individual Out-of-Pocket Maximum.

****Family Coverage**

Family Coverage refers to a subscriber and covered dependents. Benefits will not be paid for any family member until the full Family Deductible is met. Likewise, the Family Out-of-Pocket Maximum will not be considered met for any family member until the full Family Out-of-Pocket Maximum is met.

Pre-Existing Conditions

ProtectPlus excludes coverage of “pre-existing conditions” for the first six months of coverage only if the member is 19 or older on the effective date. However, if you were covered by another group health plan or individual policy before coverage begins under ProtectPlus, the pre-existing condition exclusion may not fully, or partially apply.

A pre-existing condition is one for which medical advice, diagnosis, care, or treatment was recommended from a licensed health practitioner during the six months immediately preceding the effective date of coverage under ProtectPlus.

CPA ProtectPlus Online

ProtectPlus offers you convenient access to a variety of individualized information via cpaprotectplus.com. Here are a few examples of what you can do when you visit the site:

- Find an in-network participating doctor or hospital near you including specialists and medical groups
- Download and print plan documents and forms
- “Login to My Plans” and access your personal claims history
- View informational videos
- Access wellness information
- Get help from a plan expert
- See what other members are saying about CPA ProtectPlus

Contact Information

For plan related questions and correspondence:

Banyan Administrators, LLC

1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055

Voice 1-877-480-7923

Fax 1-877-237-4519

Email cpaprotectplus@banyan-llc.com

License #0G80254

Group Insurance Trust

1800 Gateway Drive, Suite 201
San Mateo, CA 94404

1-800-556-5771

www.cpaprotectplus.com

Anthem Blue Cross Customer Service for CalCPA ProtectPlus

Members Medical 1-888-209-7847

Mental Health/Outpatient 1-888-209-7847

Mental Health/Inpatient 1-800-274-7767

Medco Pharmacy Benefit Manager

1-877-659-5144 (24/7 live customer service)

www.medco.com

Health Access 24-Hour Nurse Hotline

1-800-700-9186

The Bank of New York Mellon

1-877-472-4200

www.HSAmember.com

US Bank

1-866-273-8275

www.myhsa.usbank.com

Alliant Credit Union

1-800-328-1935 x 2291

www.alliantcreditunion.org

California Society of CPAs

Voice 1-800-922-5272

www.calcpa.org

Useful Definitions

Aggregate Deductible is met when the total of the deductible amounts satisfied by all family members exceeds two times the individual deductible amount. (except HSA 2850 plan)

Aggregate Out-of-Pocket Maximum is met when the total of the out-of-pocket payments made by all family members exceeds two times (three times for HSA 1500 plan) the individual out-of-pocket amount.

Annual Deductible (Medical) means the amount of charges you must pay for any covered services before any benefits are available to you.

Brand Name Drug is a prescription drug that has been patented and is only produced by one manufacturer.

Coinsurance/Out-of-Pocket Payment is the amount for which you are responsible when the Anthem Blue Cross negotiated rate for covered services is paid.

Copayment/Copay is the amount due and payable by you to the hospital or physician for services rendered.

Drug Maximum Allowed Amount represents the maximum amount Anthem Blue Cross will allow as covered expense for a prescription filled at a non-participating pharmacy.

Emergency is a sudden, serious and unexpected acute illness, injury, or condition that could permanently endanger health if medical treatment is not received immediately.

Generic Drug is a prescription drug that does not bear the trademark of a specific manufacturer. It is represented by the manufacturer to be chemically the same as a brand name drug.

Health Maintenance Organizations (HMOs) represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same regardless of types or levels of services provided by physicians who are employed by, or under contract with the HMO.

Health Savings Account (HSA) is a special tax-sheltered savings account that is similar to a traditional Individual Retirement Account (IRA), but designated for medical expenses. An HSA allows you to pay for current health expenses and save for future qualified medical and retiree healthcare expenses on a tax-free basis. Contributions, earnings, and distributions all are exempt from federal income and Social Security (FICA) taxes when used to pay for qualified medical expenses.

High Deductible Health Plan (HDHP) is a health insurance plan with minimum annual deductibles of \$1,200 for individuals or \$2,400 for family coverage. The annual out-of-pocket expense maximums (including deductibles and co-payments but not including premiums) cannot exceed \$6,050 for individuals or \$12,100 for families. These amounts (for 2012) are indexed annually for inflation.

In-Network describes services provided by physicians, hospitals and other providers that are in the Anthem Blue Cross network.

Lifetime Maximum Benefit is the amount of total benefits that will be paid for by the plan for each member. The plan will pay an unlimited amount during each member's lifetime, subject to an annual maximum of \$2,000,000.

Member is a plan participant or covered family member.

Negotiated Fee is the fee participating providers agree to accept as payment in full for covered services.

Non-Participating Provider is a non-participating hospital, non-participating physician or other provider who does not have a Prudent Buyer Plan Participating Agreement in effect with Anthem Blue Cross at the time services are rendered.

Out-of-Network describes services provided by physicians, hospitals and other providers that are not in the Anthem Blue Cross network.

Out-of-Pocket Maximum is the most you pay for covered expenses during the year before the plan begins paying 100% of covered expenses for the rest of the year. Only covered expenses count toward the maximum. Amounts paid toward the annual medical deductible count toward the out-of-pocket maximum. However, copays do not count toward the out-of-pocket maximum except for Anthem Blue Cross HMO plans.

Participating Provider is a participating hospital, participating physician or other provider who has entered into an agreement with Anthem Blue Cross and is included in its network.

Prescription Drug Deductible means the amount of charges you have to pay for any covered brand-name prescription drug, before any brand-name prescription drug benefits are available to you. The prescription drug deductible does not apply to generic drugs and is not integrated with the medical deductible. It does not count toward the out-of-pocket maximum.

Rights of Survivorship may apply to eligible family members following the death of a plan participant. These are rights to continued coverage under the deceased participant's plan after the legally required rights provided under COBRA or CalCOBRA have expired. Family members who are eligible, and the conditions for continuation coverage, are set forth under the plan document. Rights of Survivorship do not apply to Anthem Blue Cross HMO Participants.

Usual, Customary and Reasonable (UCR) is a charge which falls within the common range of fees billed by a majority of physicians, hospitals and other providers for a procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case.

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