ProtectPlus Healthcare Plan **2012**

CalCPA
ProtectPlus
Healthcare just for CPAs

Protect 15

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 15 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. The copayment structure is as follows:

In-Network Benefits	
Retail Pharmacies (30-day supply)	**Generic:** $10 Copay **Brand-Name Deductible:** $150 per member **Brand Formulary:** $25 Copay **Brand Non-Formulary:** $45 Copay **Self-Injectable (excl. insulin):** 30%
Mail Order (60-day supply)	**Generic:** $10 Copay **Brand-Name Deductible**: $150 per member **Brand Formulary:** $25 Copay **Brand Non-Formulary:** $45 Copay **Self-Injectable (excl. insulin):** 30%

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.

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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 15

This chart summarizes some of the major benefits offered under the CalCPA Protect 15 Copay Plan option. Benefits listed are per member costs, subject to deductibles and copayments unless otherwise stated.

Benefits	In-Network	Out-of-Network
Annual Deductible (combined in/out-of-network)	$250 per member in/out-of-network $500 family aggregate Generally, all medical benefits are covered only after the plan's deductible has been met.	
Out-of-Pocket Maximum (annual)	$3,000 per member $6,000 family aggregate	$10,000 per member
Lifetime Maximum Benefit	None $2,000,000 calendar year maximum	
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	20% of negotiated fee	Plan pays 50% of allowable fee
Inpatient Services (overnight hospital/facility stays)	20% of negotiated fee	Plan pays 50% of allowable fee, up to $540 per day
Outpatient Services (without overnight hospital/facility stays)	20% of negotiated fee	Plan pays 50% of allowable fee, up to $540 per day
Ambulatory Surgical Center	20% of negotiated fee	Plan pays 50% of allowable fee, up to $350 per visit
Emergency Room Deductible	$100	
Office Visits	$15 copay per visit. First 6 in-network visits (combined with in-network mental and nervous outpatient visits) per calendar year are not subject to the deductible.	Plan pays 50% of allowable fee
Physical Therapy, Speech Therapy (including chiropractic care) Maximum of 25 visits per year	$15 copay	Plan pays 50% of the allowable fee, up to $40 per visit
Preventive (ages 7 and up) 1 Physical per year	100% plan paid, not subject to the deductible	Plan pays up to $250
Well-Woman Care 1 Visit per year	100% plan paid, not subject to the deductible	Plan pays 50% of allowable fee
Well-Baby Care (ages 0–6)	100% plan paid, not subject to the deductible	Plan pays 50% of allowable fee
Prescription Drugs Annual Deductible (Combines in/out-of-network charges) **Note:** Some Specialty Drugs are only available through Medco's Accredo mail order program	$150 per person Applies to brand-name drugs only $300 family aggregate	
Prescription Drug - Retail **(30-day supply)**		Retail in-network copay, plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount
Generic	$10 copay	
Brand-Formulary	$25 copay	
Brand-Non-Formulary	$45 copay	
Prescription Drug - Mail Order **(60-day supply)** **(Medco mail order pharmacy only)**		Not covered
Generic	$10 copay	
Brand-Formulary	$25 copay	
Brand - Non-Formulary	$45 copay	
Self-injectable drugs - Retail or mail order (excluding insulin)	30% of prescription drug maximum allowed amount	Not covered

Notes: Where a maximum number of visits are indicated, it includes both in-network and out-of-network visits.
Copays do not apply toward satisfaction of the annual deductible or out-of-pocket amount.
Prescription drug deductible in not integrated with the medical deductible and does not apply towards the maximum out-of-pocket amount.
Member is responsible for all charges in excess of plan payments for out-of-network services.

Mental Health & Substance Abuse Benefits

CPA ProtectPlus has contracted with Anthem Blue Cross of California's network of specialists and facilities to provide members with mental health and substance abuse benefits. Outpatient treatment for mental health or substance abuse does not require pre-authorization from Anthem Blue Cross, but if you have questions regarding outpatient benefits please call 1-888-209-7847. Inpatient mental health or substance abuse services must be pre-authorized in order to be eligible for payment under the plan. If you or your family members need this type of service you must first call 1-800-274-7767 for authorization.

Please be aware that if you seek treatment from a non-network provider, your out-of-pocket costs will be substantially higher. Furthermore, claims for treatment from non-network providers are subject to review and may be rejected if they do not meet the plan's standards for necessity and appropriateness of treatment.

Mental Health and Substance Abuse

Benefits	In-Network	Out-of-Network*
Inpatient Services (overnight hospital/facility stays)	20% of negotiated fee	Plan pays 50% of allowable fee, up to $540 per day
Outpatient Services (without overnight hospital/facility stays)	20% of negotiated fee	Plan pays 50% of allowable fee, up to $540 per day
Office Visits/Therapy Sessions	$15 copay	Plan pays 50% of allowable fee, up to $540 per day

Benefits listed are per-member costs, subject to deductibles and copayments unless otherwise stated.
* Member is responsible for all charges in excess of plan payments.

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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

California Society of CPAs
Voice 1-800-922-5272
www.calcpa.org

Notes

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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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