CalCPA Health

Coverage Effective: 07/01/2022

2022 Medical Benefits

Benefits	HSA 3750		HSA 4950		45/1650/OV-1		50/2250	
Metal Tier	Silver		Bronze		Silver		Silver	
Provider Network	PPO or Select PPO		PPO or Select PPO		PPO or Select PPO		PPO or Select PPO	
Network Benefit Level	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Deductible† (Annual Member/Family)	$3,750/ $7,500	$7,500/ $15,000	$4,950/ $9,900	$9,900/ $19,800	$1,650/ $3,300	$3,300/ $6,600	$2,250/ $4,500	$4,500/ $9,000
Prescription Drug Deductible (Annual Member/Family)					$250/$500↓		$250/$500↓	
Emergency Room Deductible (per visit, waived if admitted)	n/a		n/a		$300		$300	
Inpatient Hospital/Residential Treatment Center Deductible	$250/admit without authorization		$250/admit without authorization		$250/admit without authorization		$250/admit without authorization	
Out-of-Pocket Maximum (Annual Member/Family)‡	$7,050/ $14,100	$14,100/ member	$7,050/ $14,100	$14,100/ member	$8,700/ $17,400	$16,000/ member	$8,700/ $17,400	$16,000/ member
Office Visit	30%	50%	25%	50%	$45**	50%	$50‖	50%
Specialist Visit	30%	50%	25%	50%	$65**	50%	$85‖	50%
Urgent Care	30%	50%	25%	50%	$65**	50%	$85‖	50%
LiveHealth Online Visit	0%	n/a	0%	n/a	$0**	n/a	$0‖	n/a
Preventive Care/ Immunizations (deductible waived for In-Network)	No charge	50%	No charge	50%	No charge	50%	No charge	50%
Pre/Postnatal Care	30%	50%	25%	50%	50%	50%	45%	50%
Lab Tests/X-Rays/ Diagnostic Imaging - *office setting*	30%	50%	25%	50%	50%	50%	45%	50%
Advanced Imaging (CT/PET Scans/MRI) - *office setting*	30%	50%; $800/test benefit	25%	50%; $800/test benefit	50%	50%; $800/test benefit	45%	50%; $800/test benefit
Emergency Room / Transport	30%		25%		50%		45%	
Inpatient Hospital	30%	50%; $650/ day benefit	25%	50%; $650/ day benefit	50%	50%; $650/ day benefit	45%	50%; $650/ day benefit
Outpatient Hospital Surgery	30%	50%; $350/ day benefit	25%	50%; $350/ day benefit	50%	50%; $350/ day benefit	45%	50%; $350/ day benefit
Ambulatory Surgical Center	30%	50%; $380/ day benefit	25%	50%; $380/ day benefit	50%	50%; $380/ day benefit	45%	50%; $380/ day benefit
Prescription Drug Benefits (30-day supply for retail and 90-day supply for mail-order)								
Generic↑	$15	$15 + 50%	$20	$20 + 50%	$15	$15+ 50%	$20	$20 + 50%
Brand Formulary	$45	$45 + 50%	$60	$60 + 50%	$45	$45 + 50%	$60	$60 + 50%
Brand non-Formulary	$85	$85 + 50%	$100	$100 + 50%	$85	$85 + 50%	$100	$100 + 50%
Self-Injectable	30% up to $250††	Not Covered	30% up to $500††	Not Covered	30% up to $250	Not Covered	30% up to $250	Not Covered
Home Delivery Copay	2x Retail	Not Covered	2x Retail	Not Covered	2x Retail	Not Covered	2x Retail	Not Covered

Notice: In the event of a conflict between this information and the Summary Plan Document, the benefits detailed in the Summary Plan Document are binding. Benefit changes made by the Trust are applicable to all plans on

†Applicable unless stated otherwise: All services are subject to the Annual Deductible and must be satisfied before the plan begins to pay benefits. Family coverage includes an embedded per member deductible that is equivalent

‡Includes Deductible and all copayments/coinsurance amounts. Family coverage includes an embedded per member out-of-pocket that is equivalent to the out-of-pocket for individual coverage.

‖Deductible is waived for all visits.

**Deductible is waived for the first in-network visits; 1-visit limit applies to PCP, Specialist, and Urgent Care combined.

↓Waived for generic drugs.

↑Generic mail order: 90-day supply at 1x copay

††Per script maximum applies after the deductible has been met.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.calcpahealth.com or by calling 1-877-480-7923.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,750** Individual/**$7,500** Family for participating providers and pharmacies combined. Deductible does not apply to preventative care or eye exam and glasses for children. **$7,500** Individual/**$15,000** Family for non-participating providers and pharmacies combined.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** per admission for any hospital or residential treatment center without utilization review.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$7,050** Individual/ **$14,100** Family for participating providers. **$14,100** per Individual for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, **balance-billed** charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-888-209-7847** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network hospital or doctor's office may use out-of-network providers in their facility. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without written permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	————————none————————
	Specialist visit	30% coinsurance	50% coinsurance	————————none————————
	Other practitioner office visit	30% coinsurance	50% coinsurance	Limited to 20 chiropractor visits and 12 acupuncture visits per year, combined for In/Out-of-network.
	Preventive care/screening/immunization	No charge	50% coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	$800 benefit maximum per test for out-of-network provider.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com.	Generic drugs	$15 copay (retail and mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Formulary brand drugs	$45 copay (retail)/$90 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Non-Formulary brand drugs	$85 copay (retail)/$170 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Self-injectable drugs	30% coinsurance up to $250	Not covered	Classified self-injectable drugs must be obtained through a Specialty Pharmacy Program and are subject to the terms of the program. $250 per script maximum applies after the annual deductible has been met.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility; $380 for out-of-network ambulatory surgical center.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	——————none——————
	Emergency medical transportation	30% coinsurance	30% coinsurance	——————none——————
	Urgent care	30% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Substance use disorder outpatient services	30% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	————————none————————
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 100 4-hour visits per year.
	Rehabilitation services	30% coinsurance	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Habilitation services	30% coinsurance	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 150 visits per year.
	Durable medical equipment	30% coinsurance	50% coinsurance	————————none————————
	Hospice service	30% coinsurance	50% coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	No charge	All charges after $30 reimbursement	Limited to one exam per year.
	Glasses	No copay for frames and lenses	All charges after specified reimbursement	Limited to 1 pair of glasses per year. Out-of-network reimbursement vary by service, refer to plan document.
	Dental check-up	No charge	No charge	$60 annual deductible per child.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Adult dental care
- Infertility treatment
- Long-term care
- Non-emergency care outside of the U.S.
- Hearing aids
- Adult routine eye care
- Routine foot care
- Weight loss programs
- Private-duty nursing (except covered under home health benefits)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation)
- Chiropractic Care
- Bariatric surgery

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-480-7923. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, of the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Additionally, a consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500, Sacramento, CA 95814
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,670
- **Patient pays** $4,870

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,600
Copays	$20
Coinsurance	$1,100
Limits or exclusions	$150
Total	**$4,870**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,390
- **Patient pays** $4,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,600
Copays	$170
Coinsurance	$160
Limits or exclusions	$80
Total	**$4,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CalCPA Health: PPO HSA 4950

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Individual/Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.calcpahealth.com or by calling 1-877-480-7923.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,950** Individual/**$9,900** Family for participating providers and pharmacies combined. Deductible does not apply to preventative care or eye exam and glasses for children. **$9,900** Individual/**$19,800** Family for non-participating providers and pharmacies combined.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** per admission for any hospital or residential treatment center without utilization review.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$7,050** Individual/ **$14,100** Family for participating providers. **$14,100** per Individual for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, **balance-billed** charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-888-209-7847** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network hospital or doctor's office may use out-of-network providers in their facility. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without written permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	50% coinsurance	————————none————————
	Specialist visit	25% coinsurance	50% coinsurance	————————none————————
	Other practitioner office visit	25% coinsurance	50% coinsurance	Limited to 20 chiropractor visits and 12 acupuncture visits per year, combined for In/Out-of-network.
	Preventive care/screening/immunization	No charge	50% coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	$800 benefit maximum per test for out-of-network provider.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com.	Generic drugs	$20 copay (retail and mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Formulary brand drugs	$60 copay (retail)/$120 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Non-Formulary brand drugs	$100 copay (retail)/$200 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Self-injectable drugs	30% coinsurance up to $500	Not covered	Classified self-injectable drugs must be obtained through a Specialty Pharmacy Program and are subject to the terms of the program. $250 per script maximum applies after the annual deductible has been met.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility; $380 for out-of-network ambulatory surgical center.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	——————none——————
	Emergency medical transportation	25% coinsurance	25% coinsurance	——————none——————
	Urgent care	25% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Physician/surgeon fee	25% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Substance use disorder outpatient services	25% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you are pregnant	Prenatal and postnatal care	25% coinsurance	50% coinsurance	————————none————————
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Limited to 100 4-hour visits per year.
	Rehabilitation services	25% coinsurance	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Habilitation services	25% coinsurance	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 150 visits per year.
	Durable medical equipment	25% coinsurance	50% coinsurance	————————none————————
	Hospice service	25% coinsurance	50% coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	No charge	All charges after $30 reimbursement	Limited to one exam per year.
	Glasses	No copay for frames and lenses	All charges after specified reimbursement	Limited to 1 pair of glasses per year. Out-of-network reimbursement vary by service, refer to plan document.
	Dental check-up	No charge	No charge	$60 annual deductible per child.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Adult dental care
- Infertility treatment
- Long-term care
- Non-emergency care outside of the U.S.
- Hearing aids
- Adult routine eye care
- Routine foot care
- Weight loss programs
- Private-duty nursing (except covered under home health benefits)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation)
- Chiropractic Care
- Bariatric surgery

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-480-7923. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, of the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Additionally, a consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500, Sacramento, CA 95814
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,960
- **Patient pays** $5,580

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,800
Copays	$20
Coinsurance	$610
Limits or exclusions	$150
Total	**$5,580**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $390
- **Patient pays** $5,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,800
Copays	$90
Coinsurance	$40
Limits or exclusions	$80
Total	**$5,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CalCPA Health: PPO 45/1650

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Individual/Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.calcpahealth.com or by calling 1-877-480-7923.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,650** Individual/**$3,300** Family for participating providers. Does not apply to preventative care or eye exam and glasses for children. Waived for the 1st visit to a primary, specialist, urgent care, chiropractic, acupuncture or rehabilitation therapy – combined. **$3,300** Individual/ **$6,600** Family for non-participating providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** Individual/**$500** Family for brand name drugs. **$300** per visit to any emergency room, waived if admitted. **$250** per admission for any hospital or residential treatment center without utilization review.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$8,700** Individual/ **$17,400** Family for participating providers. **$16,000** per Individual for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, **balance-billed** charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-888-209-7847** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network hospital or doctor's office may use out-of-network providers in their facility. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-877-480-7923 or visit us at www.calcpahealth.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.calcpahealth.com or call 1-877-480-7923 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without written permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit	50% coinsurance	——————none——————
	Specialist visit	$65 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	$45 copay/visit for chiropractor and acupuncture	50% coinsurance	Limited to 20 chiropractor visits and 12 acupuncture visits per year, combined for In/Out-of-network.
	Preventive care/screening/immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	$800 benefit maximum per test for out-of-network provider.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com.	Generic drugs	$15 copay (retail and mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Formulary brand drugs	$45 copay (retail)/$90 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Non-Formulary brand drugs	$85 copay (retail)/$170 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30 day supply for retail and 31-90 day supply for mail order.
	Self-injectable drugs	30% coinsurance up to $250	Not covered	Classified self-injectable drugs must be obtained through a Specialty Pharmacy Program and are subject to the terms of the program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility; $380 for out-of-network ambulatory surgical center.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	50% coinsurance	50% coinsurance	——————none——————
	Emergency medical transportation	50% coinsurance	50% coinsurance	——————none——————
	Urgent care	$65 copay/visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Physician/surgeon fee	50% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Mental/Behavioral health inpatient services	50% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Substance use disorder outpatient services	50% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Substance use disorder inpatient services	50% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you are pregnant	Prenatal and postnatal care	50% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	50% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Limited to 100 4-hour visits per year.
	Rehabilitation services	$45 copay/visit	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Habilitation services	$45 copay/visit	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Skilled nursing care	50% coinsurance	50% coinsurance	Limited to 150 visits per year.
	Durable medical equipment	50% coinsurance	50% coinsurance	——————none——————
	Hospice service	50% coinsurance	50% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	All charges after $30 reimbursement	Limited to one exam per year.
	Glasses	No copay for frames and lenses	All charges after specified reimbursement	Limited to 1 pair of glasses/year; reimbursement for out-of-network vary by service, refer to plan document
	Dental check-up	No charge	No charge	$60 annual deductible per child.

Excluded Services & Other Covered Services:

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www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,990
- **Patient pays** $4,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$20
Coinsurance	$2,880
Limits or exclusions	$150
Total	**$4,550**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,740
- **Patient pays** $2,660

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$580
Coinsurance	$520
Limits or exclusions	$80
Total	**$2,680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CalCPA Health: PPO 50/2250

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Individual/Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.calcpahealth.com or by calling 1-877-480-7923.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,250** Individual/**$4,500** Family for participating providers. Does not apply to preventative care, eye exam and glasses for children or office visits with a dollar copayment benefit. **$4,500** Individual/ **9,000** Family for non-participating providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** Individual/**$500** Family for brand name drugs. **$300** per visit to any emergency room, waived if admitted. **$250** per admission for any hospital or residential treatment center without utilization review	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$8,700** Individual/ **$17,400** Family for participating providers. **$16,000** per Individual for non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, **balance-billed** charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-888-209-7847** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network hospital or doctor's office may use out-of-network providers in their facility. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without written permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit	50% coinsurance	——————none——————
	Specialist visit	$85 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	$50 copay/visit for chiropractor and acupuncture	50% coinsurance	Limited to 20 chiropractor visits and 12 acupuncture visits per year, combined for In/Out-of-network.
	Preventive care/screening/immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	45% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	45% coinsurance	50% coinsurance	$800 benefit maximum per test for out-of-network provider.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com.	Generic drugs	$20 copay (retail and mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Formulary brand drugs	$60 copay (retail)/$120 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Non-Formulary brand drugs	$100 copay (retail)/$200 copay (mail order)	In-network copay plus 50% coinsurance	Covers up to a 30-day supply for retail and 31 to 90-day supply for mail order.
	Self-injectable drugs	30% coinsurance up to $250	Not covered	Classified self-injectable drugs must be obtained through a Specialty Pharmacy Program and are subject to the terms of the program.
If you have outpatient surgery	Facility fe (e.g., ambulatory surgery center)	45% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility; $380 for out-of-network ambulatory surgical center.
	Physician/surgeon fees	45% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	45% coinsurance	45% coinsurance	——————none——————
	Emergency medical transportation	45% coinsurance	45% coinsurance	——————none——————
	Urgent care	$85 copay/visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	45% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Physician/surgeon fee	45% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	45% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Mental/Behavioral health inpatient services	45% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
	Substance use disorder outpatient services	45% coinsurance	50% coinsurance	Benefit max of $350 for out-of-network facility.
	Substance use disorder inpatient services	45% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you are pregnant	Prenatal and postnatal care	45% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	45% coinsurance	50% coinsurance	$650 benefit maximum per day for out-of-network providers.
If you need help recovering or have other special health needs	Home health care	45% coinsurance	50% coinsurance	Limited to 100 4-hour visits per year.
	Rehabilitation services	$50 copay/visit	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Habilitation services	$50 copay/visit	50% coinsurance	Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined.
	Skilled nursing care	45% coinsurance	50% coinsurance	Limited to 150 visits per year.
	Durable medical equipment	45% coinsurance	50% coinsurance	——————none——————
	Hospice service	30% coinsurance	50% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	All charges after $30 reimbursement	Limited to one exam per year.
	Glasses	No copay for frames and lenses	All charges after specified reimbursement	Limited to 1 pair of glasses/year; reimbursement for out-of-network vary by service, refer to plan document
	Dental check-up	No charge	No charge	$60 annual deductible per child.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Adult dental care
- Infertility treatment
- Long-term care
- Non-emergency care outside of the U.S.
- Hearing aids
- Adult routine eye care
- Routine foot care
- Weight loss programs
- Private-duty nursing (except covered under home health benefits)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation)
- Chiropractic Care
- Bariatric surgery

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-480-7923. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, of the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Additionally, a consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500, Sacramento, CA 95814
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,740
- **Patient pays** $4,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,750
Copays	$20
Coinsurance	$880
Limits or exclusions	$150
Total	**$4,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,170
- **Patient pays** $4,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,750
Copays	$290
Coinsurance	$110
Limits or exclusions	$80
Total	**$4,230**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CalCPA Health
Health plans for CPAs since 1959

Anthem BlueCross

Looking for a doctor?

Finding one online is fast and easy

Use our online **Find a Doctor tool** to look for doctors, hospitals, labs and other health care providers in your Anthem Blue Cross plan. Check if your favorite doctor is part of your plan, or look for one near you. Avoid getting care from doctors outside of your plan if you can — it will cost you more or your plan may not cover it all.

All CalCPA Health medical plans utilize the Anthem Blue Cross network of providers. Follow the steps below to find an in-network provider.

Visit anthem.com/ca and go to "Find a Doctor"

If using "Search as a Member",
simply log in with the profile you created and search for a provider - the network you belong to will be pre-selected.

If using "Search as Guest",
you must select one of the following networks:

For PPO/HSA plans in California,
choose Blue Cross PPO (Prudent Buyer) - Large Group.

For Select PPO/HSA plans in California,
choose Select PPO.

For PPO/HSA/Select PPO/Select PPO HSA plans outside of California,
choose National PPO (BlueCardPPO).

For HMO plans,
choose Blue Cross HMO (CACare) - Large Group.

For Select HMO plans,
choose Select HMO.

Select a doctor to see more information, such as:
Training • Specialties • Languages spoken • Address (including a map) • Phone number

Going mobile

Use your mobile device to search for doctors, hospitals and more with our free app from the App Store® or Google Play™. Just search for Anthem Anywhere and download the app.

CalCPA Health / 1710 Gilbreth Road, Suite 300 Burlingame, Ca 94010 / (877) 480-7923 / CalCPAHealth.com

You've got quick access to your health care!

Register on anthem.com/ca or the Anthem BC Anywhere mobile app.*

Have your member ID card handy to register

From your computer

- Go to anthem.com/ca/register/
- Provide the information requested
- Create a username and password
- Set your email preferences
- Follow the prompts to complete your registration

From your mobile device

- Download the free Anthem BC Anywhere mobile app and select **Register**
- Confirm your identity
- Create a username and password
- Set your email preferences
- Follow the prompts to complete your registration

Need help signing up?

Call us at **1-866-755-2680.**

Anthem BlueCross

* You must be 18 years or older to register your own account.

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Got ID cards?

We know the peace of mind your member identification (ID) card brings you and your loved ones. That's why Anthem Blue Cross (Anthem) and Anthem Blue Cross Life and Health Insurance Company have made sure you never have to leave home without it.

If you have not yet received your permanent ID card and want to access health care services, you can print a temporary ID card online through our website, **anthem.com/ca**.

Tell me how

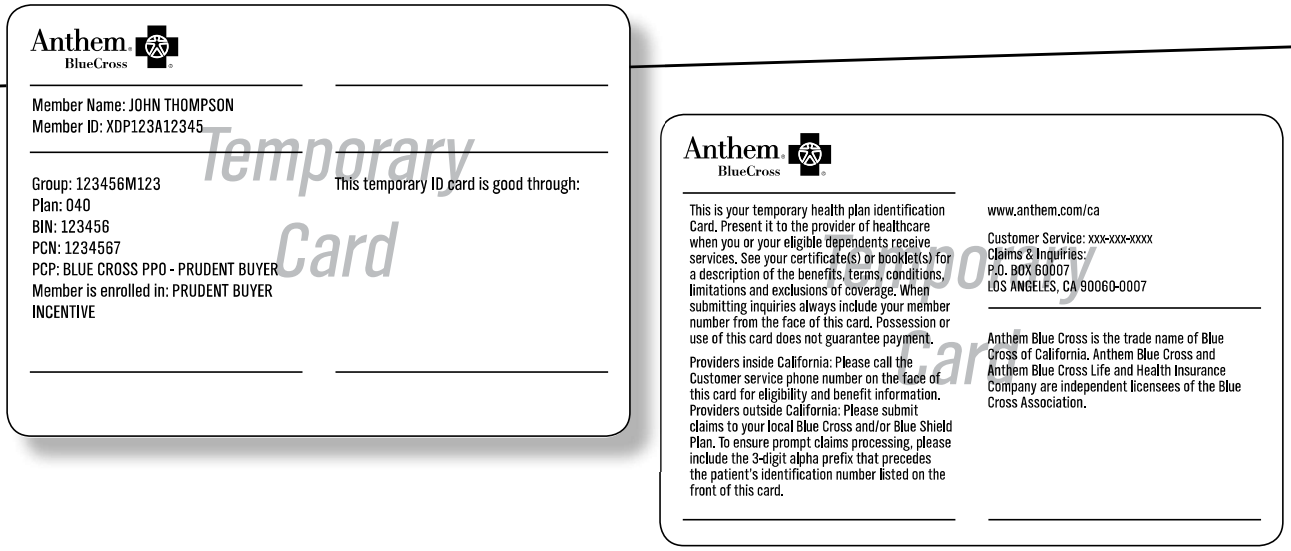
It's a simple four-step process:

1. Before starting, check with your employer to confirm your information has been added into Anthem's system. Your name, date of birth and ZIP code must match exactly what is on file with Anthem. You cannot register before your plan effective date.
2. Go to **anthem.com/ca**, in the top-right corner log in to the secure Member site. If you have not visited this site before, you will need to establish an account by clicking on "Register." When you are asked for a member ID number during online registration, enter it as it appears on your member ID card. If you do not have your member ID number, call Anthem Customer Service or get it from Human Resources.
3. Click the "Customer Support" tab in the top right corner. Select the "Print Temporary ID Card" option and follow the instructions on how to create and print the temporary ID card.
4. You can print the ID card using your own printer and use the card at your next doctor's appointment.

Take a look at a sample below.

Note: The temporary ID card may not include all of your benefit information.

If you have any questions, a Customer Service number is on the temporary ID card. We hope this option gives you the peace of mind you and your family deserve.



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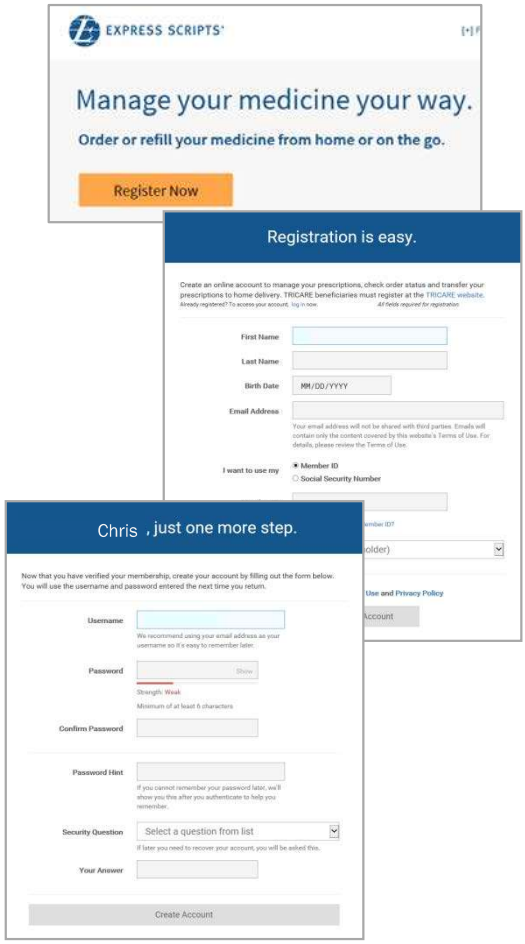
EXPRESS SCRIPTS®

Registering with Express Scripts

Online access to savings and convenience



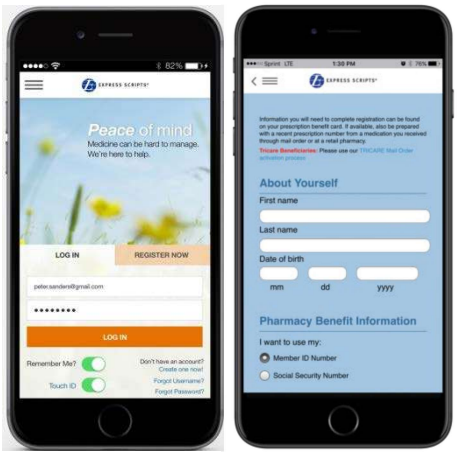
Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts mobile app

Register now so you can experience:

- **More savings.**
  Compare prices of medicines at multiple pharmacies. Get free standard shipping* from the Express Scripts Pharmacy℠.
- **More convenience.**
  Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- **More confidence.**
  Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- **More flexibility.**
  Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.



- Go to express-scripts.com, select **Register Now** or download the **Express Scripts Mobile App** for free from your mobile device's app store and select **Register Now**
- Complete the information requested, including personal information and member ID number or Social Security Number (SSN), create your user name and password, along with security information in case you ever forget your password
- Click **Register now** and you're registered
- To set preferences**, select **Manage Communications Preferences** from the menu under **My Account**, scroll to **Communication** and **Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.

Members who have **Apple's touch ID authentication** on their iPhone or iPad devices can enable it to login to their Express Scripts account on the mobile app, if desired.

* Standard shipping costs are included as part of your prescription plan benefit.

** Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, Android™, Windows Phone®, Amazon, and Blackberry® mobile devices.