# CalCPA Health: PPO HSA PRx 1700

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

**Coverage Period: 01/01/2026 – 12/31/2026**

**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?** | **$1,700** Individual/**$3,400** Family for participating providers and pharmacies combined. No Individual on a Family policy will exceed a deductible of **$3,400**.<br>Deductible does not apply to preventative care, eye exam and glasses for children or Standard Generic Preventative Rx.<br><br>**$3,400** Individual/**$6,800** 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. **$7,500** Individual/ **$15,000** Family for participating providers.<br>**$15,000** 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**. |
| **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. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider. |

| | | |
|---|---|---|
| **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% coinsurance | 50% coinsurance | ————————none———————— |
| | Specialist visit | 45% coinsurance | 50% coinsurance | ————————none———————— |
| | Other practitioner office visit | 45% 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) | 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**<br><br>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. $250 per script maximum applies after the annual deductible has been met. |
| **If you have outpatient surgery** | Facility fee (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 | 45% coinsurance | 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** | Outpatient services | 45% coinsurance | 50% coinsurance | Benefit max of $350 for out-of-network facility. |
| | 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 | 45% coinsurance | 50% coinsurance | Limited to 25 visits per year for In/Out-of-network physical and occupational therapy combined. |
| | Habilitation services | 45% coinsurance | 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 | 45% 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
- 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)
- Infertility treatment - 3 oocyte egg retrievals/lifetime
- 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** $3,040
- **Patient pays** $4,500

**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 | $1,400 |
| Copays | $20 |
| Coinsurance | $2,940 |
| Limits or exclusions | $150 |
| **Total** | **$4,500** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,810
- **Patient pays** $2,590

**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 | $1,400 |
| Copays | $350 |
| Coinsurance | $760 |
| Limits or exclusions | $80 |
| **Total** | **$2,590** |

# 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 Individual 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.