Your summary of benefits

Anthem BlueCross

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Green Dot Public Schools

OPTION 1: Your Plan: Custom Exclusive Premier $10/$20/$200 admit/$100 op

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$100 single / $200 family	$3,000 single / $6,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$2,000 single / $6,000 family	$9,000 single / $18,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$10 copay per visit	50% coinsurance
Specialist care visit	$20 copay per visit	50% coinsurance
Prenatal and Post-natal Care	$10 copay per visit	50% coinsurance
Other practitioner visits:		
Retail health clinic	$10 copay per visit	50% coinsurance
On-line Visit	$10 copay per visit	50% coinsurance
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per calendar year.*	$10 copay per visit	50% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visits per calendar year.*	$10 copay per visit	50% coinsurance

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Other services in an office:		
Allergy testing	No charge	50% coinsurance
Chemo/radiation therapy	$10 copay per visit	50% coinsurance
Hemodialysis	$10 copay per visit	50% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	No charge	50% coinsurance
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance
Freestanding Lab	No charge	50% coinsurance
Outpatient Hospital	No charge	50% coinsurance
X-ray:		
Office	No charge	50% coinsurance
Freestanding Radiology Center	No charge	50% coinsurance
Outpatient Hospital	No charge	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	No charge	50% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	No charge	50% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	No charge	50% coinsurance
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Deductible waived if admitted.*	$100 deductible per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground	Covered as In-Network

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Urgent Care (office setting) *Costs may vary by site of service.*	$10 copay per visit	50% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	No charge	50% coinsurance
Facility visit:		
Facility fees	No charge	50% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per admission.*	$100 copay per admission	50% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per admission.*	$100 copay per admission	50% coinsurance
Doctor and other services	No charge	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Additional $500 deductible applies if you do not receive preauthorization for non-emergency admission at an Out-of-Network provider. Coverage for Out-of-Network Provider is limited to $1,000 maximum per day for non-emergency admission.*	$200 copay per admission	50% coinsurance
Doctor and other services	No charge	50% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visits per calendar year.*	$10 copay per visit	50% coinsurance

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Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	$10 copay per visit	50% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per admission.*	$10 copay per visit	50% coinsurance
Cardiac rehabilitation		
Office	$10 copay per visit	50% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per admission.*	$10 copay per visit	50% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 days per calendar year.*	No charge	50% coinsurance
Hospice	No charge	50% coinsurance
Durable Medical Equipment	No charge	50% coinsurance
Prosthetic Devices	No charge	50% coinsurance
Hemodialysis (in freestanding hemodialysis center) *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	$10 copay per visit	50% coinsurance
Home Infusion Therapy *Coverage for Out-of-Network Provider is limited to $600 per day.*	$10 copay per visit	50% coinsurance

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Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.

- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to five consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Questions: (855) 333-5730 or visit us at www.anthem.com/ca
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