Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Green Dot Public Schools (CA): Custom Anthem Exclusive Classic PPO 100/10/20/200 admit/100 OP

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$10 copay per visit after deductible is met
Mental Health & Substance Use Disorder Services	$10 copay per visit after deductible is met
Specialist care	$20 copay per visit after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$100 person / $200 family	$3,000 person / $6,000 family
Overall Out-of-Pocket Limit	$2,000 person / $6,000 family	$9,000 person / $18,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. (Excluding Infertility treatment) In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$20 copay per visit after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity services		
Prenatal and Postnatal care	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Delivery	$200 copay per pregnancy after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office* *Maximum of $150 member cost share per drug.*	No charge	50% coinsurance after deductible is met
Surgery	$10 copay per surgery deductible does not apply	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
X-Ray		
Office	No charge	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit and No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$100 copay per trip after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	50% coinsurance after deductible is met
Doctor Services	No charge	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$100 copay per visit after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	$100 copay per visit after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply. Member is responsible for an additional $500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to Out-of-Network Providers.*		
Facility Fees	$200 copay per admission after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.*		
Office	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office	$10 copay per visit after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge	50% coinsurance after deductible is met
Inpatient Hospice	No charge	50% coinsurance after deductible is met
Durable Medical Equipment	No charge	50% coinsurance after deductible is met
Prosthetic Devices	No charge	50% coinsurance after deductible is met
Infertility Treatment *Covered Services include artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), ZIFT (Zygote intra-fallopian transfer), supplies, appliances, and Drugs administered in a Physician's office.* *Coverage is limited to $2,000 maximum per benefit period.* *Not Covered: Reversals of elective sterilizations.*	50% coinsurance	50% coinsurance

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***CA Essential DMHC*** *Drugs not included on the CA Essential DMHC drug list will not be covered.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Tier 1 - Typically Generic	$15 copay per prescription (retail and home delivery)	$25 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$35 copay per prescription (retail) and $70 copay per prescription (home delivery)	$45 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$70 copay per prescription (retail) and $140 copay per prescription (home delivery)	$80 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $150 per prescription (retail) and 20% coinsurance up to $300 per prescription (home delivery)	30% coinsurance up to $150 per prescription (retail) and Not covered (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- The representations of benefits in this document are subject to California Department of Managed Health Care (DMHC) approval and are subject to change.

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 Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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

Anthem

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Get help in your language

Language Assistance Services

Curious to know what all this says?
We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta?
Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نخوانیدنمی توانیم از شخصی بخواهیم که آن را برای شما بخواند. کمک دریافت کنید. همچنین می توانید این نامه را به زبان خودتان بگیرید. برای دریافت کمک فوراً با شماره 1-888-254-2721. (TTY/TDD: 711) تماس بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean
중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi
ਕੀ ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian
ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf