
 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit anthem.com/ca/pge; see the *Summary of Benefits Handbook* at spd.mypgebeneffits.com; or call **1-800-964-0530**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call **1-800-964-0530** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>in-network</u> and <u>out-of-network providers</u> combined: \$1,000 person / \$2,000 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Some <u>preventive care</u> , primary care visits, urgent care, prenatal and postnatal office visits, some prescription drugs, and hospice are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the Common Medical Events chart below for other costs for services this <u>plan</u> covers.
What is the out-of-pocket limit for this plan?	For <u>in-network providers</u> and <u>out-of-network providers</u> combined: \$2,400 person / \$4,800 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for non-compliance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use an in-network provider?	Yes. See the Common Medical Events chart below for costs, and visit anthem.com/ca/pge or call 1-800-964-0350 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay more if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>in-network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No <u>deductible</u> . Visits 1–4 covered at 100%; visits 5+ covered at 10% <u>coinsurance</u> .
	<u>Specialist visit</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Select <u>preventive care/screening/immunization</u>	No charge	No charge	Free if included on list of free <u>preventive</u> services, available at myggebenefits.com . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Other practitioner office visit	20% <u>coinsurance</u> for chiropractic and acupuncture	20% <u>coinsurance</u> for chiropractic and acupuncture	Visits 1-5 covered at 10% <u>coinsurance</u> ; visits 6+ covered at 20% <u>coinsurance</u> . <u>Preauthorization</u> required for 6+ visits for chiropractic and acupuncture.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at express-scripts.com	Generic drugs	Retail: 15% <u>coinsurance</u> Mail order: 10% <u>coinsurance</u>	Retail: 15% <u>coinsurance</u> Mail order: N/A	Drugs on Mandatory Mail-Order drug list covered only at mail order after first 3 fills at retail. Drugs on <u>preventive</u> list are free through mail order only.
	Preferred brand drugs	Retail: 25% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Retail: 25% <u>coinsurance</u> Mail order: N/A	Drugs on Mandatory Mail-Order drug list covered only at mail order after first 3 fills at retail.
	Non-preferred brand drugs	Retail: 25% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Retail: 25% <u>coinsurance</u> Mail order: N/A	Penalty may apply if generic available. Drugs on <u>preventive</u> list are free through mail order only.
	<u>Specialty drugs</u>	Covered as any other drug	Covered as any other drug	100% penalty may apply for using retail after 3 fills. Certain specialty drugs can be obtained through mail order only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No deductible. Visits 1-4 covered as primary care at 100%; visits 5+ covered at 10% <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required; \$300 penalty if not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No deductible. Includes day treatment and intensive outpatient (IOP).
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required; \$300 penalty if you fail to notify Beacon Health Options within 48 hours.
If you are pregnant	Office visits	No charge	No charge	Diagnostics/X-rays/labwork covered separately.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for delivery and all inpatient services; \$300 penalty if not obtained.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required. \$300 penalty, non-coverage or reduced coverage if not obtained.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Visits 1-5 covered at 10% <u>coinsurance</u> ; visits 6+ covered at 20% <u>coinsurance</u> . <u>Preauthorization</u> required for 25+ visits.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for 25+ visits.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required; \$300 penalty, non-coverage or reduced coverage if not obtained.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for purchases or cumulative rentals over \$1,000; \$300 penalty, non-coverage or reduced coverage if not obtained. For specific exclusions, see <i>What the HAP Doesn't Cover</i> in the <i>Summary of Benefits Handbook</i> at spd.mypgebenefits.com .
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> required; \$300 penalty, non-coverage or reduced coverage if not obtained.
If your child needs dental or eye care	Children's eye exam, glasses, dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Most coverage provided outside the United States. See www.anthem.com/ca/pge
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (1 per ear every 3 years)
- Infertility Treatment (up to a lifetime maximum of \$7,000)
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The [plan](#) at **1-800-964-0530**; your state insurance department; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 / Telephone: **1-800-964-0530** / Website: anthem.com/ca/pge. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-964-0530.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-964-0530.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-964-0530.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-964-0530.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only (single) coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,000*
■ Specialist (prenatal) office visits	No charge
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%
■ Out-of-pocket limit**	\$2,400

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/delivery professional services
 Childbirth/delivery facility services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,460**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,000*
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%
■ Out-of-pocket limit**	\$2,400

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$70
The total Joe would pay is	\$2,470**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,000*
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%
■ Out-of-pocket limit**	\$2,400

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*X-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$180
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,180

*If you earn maximum Health Account credits (\$1,000 per year), you'll have enough Health Account credits to pay your annual deductible. For information about the Health Account, see mypgebenefits.com. **If you reach the annual out-of-pocket limit (\$2,400/single coverage or \$4,800/family coverage), the Anthem HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket limit includes amounts you pay toward your deductible. It **does not include** penalty charges, amounts that exceed the reasonable and customary amounts for out-of-network charges, or charges for services that aren't covered.