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.mypgebenefits.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/**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers **$120** person / **$240** two people / **$320** three or more people For out-of-network providers **$240** person / **$480** two people / **$680** three or more people	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. Copayments do not count toward your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart below for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**Anthem medical limit** for in-network providers **$750** person / **$1,500** two or more people For out-of-network providers **$1,000** person / **$2,000** family **Separate Express Scripts prescription drug limit** of **$500** person / **$1,000** two or more people	The medical and prescription drug out-of-pocket limits are the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall medical and prescription drug family out-of-pocket limits have been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing 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 out-of-pocket limit.
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 **1-800-964-0530** for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay more 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 in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/visit	30% coinsurance	None
	Specialist visit	$20 copay/visit	30% coinsurance	None
	Select preventive care/screening/ immunization	$10 copay/visit primary care physician and $20 copay/visit specialist	30% coinsurance	There may be other levels of copays or coinsurance that are contingent on what services are provided. See *NAP at a Glance* in the 2011 *Summary of Benefits Handbook* (pp. 117-119 Union version) at **spd.mypgebenefits.com**.
	Other practitioner office visit	20% coinsurance for chiropractic & acupuncture	30% coinsurance for chiropractic & acupuncture	Coverage is limited to 15 visits/year for non-network chiropractic care; 20 visits/year for in-network acupuncture; 15 visits/year for non-network acupuncture.
If you have a test	Diagnostic test (X-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **express-scripts.com**	Generic drugs	Retail: 15% coinsurance Mail order: 10% coinsurance	Retail: 20% coinsurance Mail order: N/A	5% penalty for using retail for maintenance drugs after 3 fills.
	Preferred brand drugs	Retail: 25% coinsurance Mail order: 20% coinsurance	Retail: 30% coinsurance Mail order: N/A	5% penalty for using retail for maintenance drugs after 3 fills. Penalty may apply if generic available.
	Non-preferred brand drugs	Retail: 25% coinsurance Mail order: 20% coinsurance	Retail: 30% coinsurance Mail order: N/A	5% penalty for using retail for maintenance drugs after 3 fills. Penalty may apply if generic available.
	Specialty drugs	Covered as any other drug	Covered as any other drug	5% penalty may apply for using retail after 3 fills.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit	30% coinsurance	Copay waived if admitted.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$35 copay/visit	$35 copay/visit	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$10 copay/visit primary care; $20 copay/visit specialist	30% coinsurance	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 have a hospital stay	Facility fee (e.g., hospital room)	$100 copay	30% coinsurance	Preauthorization required; $300 penalty if not obtained for non-emergency care.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$10 copay/individual visit $5 copay/group visit	30% coinsurance	**Mental/behavioral health:** No charge for initial visit for medication evaluation. **Substance use disorder:** No limitations or exceptions.
	Inpatient services	0% coinsurance	30% coinsurance	Preauthorization required; $300 penalty if you fail to notify Beacon Health Options within 48 hours.
If you are pregnant	Office visits	$20 copay/visit	30% coinsurance	Diagnostics/X-rays/labwork covered separately.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Preauthorization required for delivery and all inpatient services; $300 penalty if not obtained.
	Childbirth/delivery facility services	$100 copay	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization required. $300 penalty, non-coverage or reduced coverage if not obtained.
	Rehabilitation services	20% coinsurance	30% coinsurance	Preauthorization required for 25+ visits.
	Habilitation services	20% coinsurance	30% coinsurance	Preauthorization required for 25+ visits.
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization required. $300 penalty, non-coverage or reduced coverage if not obtained.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization required for purchases or cumulative rentals over $1,000; $300 penalty, non-coverage or reduced coverage if preauthorization not obtained. For specific exclusions, see *What NAP Doesn't Cover* in the 2011 *Summary of Benefits Handbook* (pp. 139-142 Union version) at **spd.mypgebenefits.com**.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization required. $300 penalty, non-coverage or reduced coverage if not obtained.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's 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 if approved under Home Health benefit

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, kwiijigo 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	$120
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	10%
Out-of-pocket limit*	$750

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**

In this example, Peg would pay:

Cost Sharing	
Deductible	$120
Copayments	$420
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$810***

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$120
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	25%
Out-of-pocket limit*	$750

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**

In this example, Joe would pay:

Cost Sharing	
Deductible	$120
Copayments	$340
Coinsurance	$560
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$820***

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$120
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	20%
Out-of-pocket limit*	$750

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**

In this example, Mia would pay:

Cost Sharing	
Deductible	$120
Copayments	$220
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

*If you reach the annual out-of-pocket limit ($750/person or $1,500/two or more people), the Anthem NAP 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.

The plan would be responsible for the other costs of these EXAMPLE covered services.