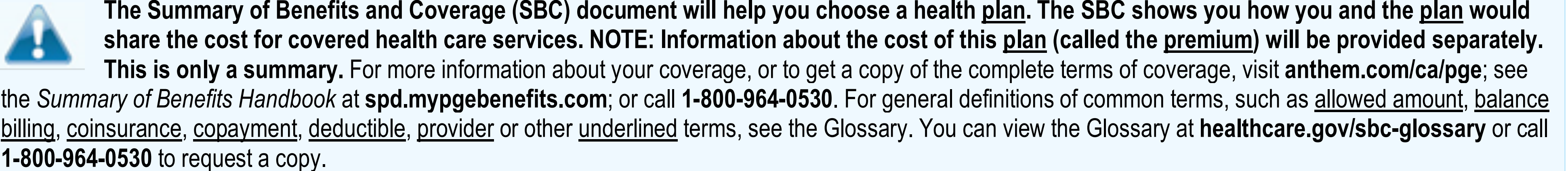

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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 **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 in-network and out-of-network providers combined: **$1,000** person / **$2,000** family	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. Some preventive care, primary care visits, urgent care, prenatal and postnatal office visits, some prescription drugs, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at **healthcare.gov/coverage/preventive-care-benefits**.
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?	For in-network providers and out-of-network providers combined: **$2,400** person / **$4,800** family	The out-of-pocket limit is 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 family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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% coinsurance	10% coinsurance	Visits 1–4 covered at 100%, in-network and out-of-network. Visits 5+ covered at 10% coinsurance, no deductible.
	Specialist visit	20% coinsurance	20% coinsurance	None
	Select preventive care/screening/ immunization	No charge	No charge	Free if included on list of free preventive services, available at **mypgebenefits.com**. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Other practitioner office visit	20% coinsurance for chiropractic and acupuncture	20% coinsurance for chiropractic and acupuncture	Visits 1-5 covered at 10% coinsurance; visits 6+ covered at 20% coinsurance. Preauthorization required for 6+ visits for chiropractic and acupuncture.
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% 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: 15% coinsurance Mail order: N/A	Drugs on Mandatory Mail-Order drug list covered only at mail order after first 3 fills at retail. Drugs on preventive list are free through mail order only.
	Preferred brand drugs	Retail: 25% coinsurance Mail order: 20% coinsurance	Retail: 25% coinsurance Mail order: N/A	Drugs on Mandatory Mail-Order drug list covered only at mail order after first 3 fills at retail. Penalty may apply if generic available. Drugs on preventive list are free through mail order only.
	Non-preferred brand drugs	Retail: 25% coinsurance Mail order: 20% coinsurance	Retail: 25% coinsurance Mail order: N/A	
	Specialty drugs	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% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% 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 need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	No deductible. Visits 1-4 covered as primary care at 100%; visits 5+ covered at 10% coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization required; $300 penalty if not obtained.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% coinsurance	10% coinsurance	No deductible required. Includes day treatment and intensive outpatient (IOP).
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization 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% coinsurance	20% coinsurance	Preauthorization required for delivery and all inpatient services; $300 penalty if not obtained.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization required. $300 penalty, non-coverage or reduced coverage if not obtained.
	Rehabilitation services	20% coinsurance	20% coinsurance	Visits 1-5 covered at 10% coinsurance; visits 6+ covered at 20% coinsurance. Preauthorization required for 25+ visits.
	Habilitation services	20% coinsurance	20% coinsurance	Preauthorization required for 25+ visits.
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization required; $300 penalty, non-coverage or reduced coverage if not obtained.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization required for purchases or cumulative rentals over $1,000; $300 penalty, non-coverage or reduced coverage if not obtained.
	Hospice services	No charge	No charge	Preauthorization 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 **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 **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 **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 **dol.gov/ebsa/healthreform**.

Does this plan provide Minimum Essential Coverage? Yes.

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** **$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**

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**

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**

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 reach the annual out-of-pocket limit ($2,400/single coverage or $4,800/family coverage), the Gold Plan 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.