




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?	\$120 person / \$240 two people / \$320 three or more people	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 <u>deductible</u> 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.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. <u>Copayments</u> do not count toward your <u>deductible</u> .
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?	\$750 person / \$1,500 two or more people Separate Express Scripts prescription drug limit of \$500 person / \$1,000 two or more people	The medical and prescription drug <u>out-of-pocket limits</u> are 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 medical and prescription drug family <u>out-of-pocket limits</u> have been met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <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 1-800-964-0530 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a provider <u>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>copay</u> /visit	\$10 <u>copay</u> /visit	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit	None
	Select <u>preventive care/screening/immunization</u>	\$10 <u>copay</u> /visit primary care physician and \$20 <u>copay</u> /visit <u>specialist</u>	\$10 <u>copay</u> /visit primary care physician and \$20 <u>copay</u> /visit <u>specialist</u>	There may be other levels of <u>copays</u> or <u>coinsurance</u> that are contingent on what services are provided. See <i>CAP at a Glance</i> in the Union 2011 edition of the <i>Summary of Benefits Handbook</i> at spd.mypgebenefits.com (paper copy, pp. 144-145 Union 2011 edition).
	Other practitioner office visit	20% <u>coinsurance</u> for chiropractic & acupuncture	20% <u>coinsurance</u> for chiropractic & acupuncture	Coverage is limited to 20 visits/year for acupuncture.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available by calling Express Scripts: 1-800-718-6590	Generic drugs	Retail: 15% <u>coinsurance</u> Mail order: 10% <u>coinsurance</u>	Retail: 20% <u>coinsurance</u> Mail order: N/A	5% penalty for using retail for maintenance drugs after 3 fills.
	Preferred brand drugs	Retail: 25% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u> 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% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u> Mail order: N/A	5% penalty for using retail for maintenance drugs after 3 fills. Penalty may apply if generic available.
	<u>Specialty drugs</u>	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 <u>copay</u> /visit	\$35 <u>copay</u> /visit	<u>Copay</u> waived if admitted.
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$10 <u>copay</u> /visit primary care; \$20 <u>copay</u> /visit <u>specialist</u>	\$10 <u>copay</u> /visit primary care; \$20 <u>copay</u> /visit <u>specialist</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 have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u>	\$100 <u>copay</u>	<u>Preauthorization</u> required; \$300 penalty if not obtained for non-emergency care.
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	\$10 <u>copay</u> /individual visit \$5 <u>copay</u> /group visit	\$10 <u>copay</u> /individual visit \$5 <u>copay</u> /group visit	Mental/behavioral health: No charge for initial visit for medication evaluation. Substance use disorder: No limitations or exceptions.
	Inpatient services	0% <u>coinsurance</u>	0% <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	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit	Diagnostics/X-rays/labwork covered separately.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Included in facility fee	<u>Preauthorization</u> required for delivery and all inpatient services; no penalty for failure to <u>preauthorize</u> inpatient delivery claims.
	Childbirth/delivery facility services	\$100 <u>copay</u>	\$100 <u>copay</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <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>	<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>	10% <u>coinsurance</u>	10% <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 <u>preauthorization</u> not obtained. For specific exclusions, see <i>What CAP Doesn't Cover</i> in the Union 2011 edition of the <i>Summary of Benefits Handbook</i> at spd.mypgebenefits.com (paper copy, pp. 162-164, Union 2011 edition).
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<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	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 <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic Surgery• Dental Care (Adult)• Long-Term Care	<ul style="list-style-type: none">• Most coverage provided outside the United States. See anthem.com/ca/pge• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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 <u>plan</u> document.)		
<ul style="list-style-type: none">• Acupuncture• Bariatric Surgery	<ul style="list-style-type: none">• Chiropractic Care• Hearing Aids (1 per ear every 3 years)	<ul style="list-style-type: none">• 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 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, 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 <u>plan's overall deductible</u>	\$120
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other coinsurance</u>	10%
■ <u>Out-of-pocket limit*</u>	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductible	\$120
Copayments	\$420
Coinsurance	\$700
<i>What isn't covered</i>	
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 <u>plan's overall deductible</u>	\$120
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other coinsurance</u>	25%
■ <u>Out-of-pocket limit*</u>	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductible	\$120
Copayments	\$340
Coinsurance	\$560
<i>What isn't covered</i>	
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 <u>plan's overall deductible</u>	\$120
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other coinsurance</u>	20%
■ <u>Out-of-pocket limit*</u>	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductible	\$120
Copayments	\$220
Coinsurance	\$180
<i>What isn't covered</i>	
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 CAP 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.