This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.anthem.com/ca/pge**; in the *Summary of Benefits Handbook* at **spd.mypgebenefits.com**; or or by calling **1-800-964-0530**.

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 Doesn't apply to preventive care, urgent care, prenatal and postnatal office visits, primary care visits and hospice.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use (except for select services that don't require a deductible). Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network and out-of-network providers combined: **$2,400** person / **$4,800** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca/pge** or call **1-800-964-0530** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.
What is the Health Account?	The Health Account is a tax-free account funded by PG&E. You can use the credits in your account to help pay for deductibles and other eligible out-of-pocket health care expenses for you and your family.	Each year, PG&E automatically credits your account, plus you can earn additional credits. **Single Coverage:** • Up to $1,000 ($500 automatic credit + extra $250 for health screening + extra $250 for tobacco-free test or program; must agree to share results with testing agency) **Family Coverage:** • Up to $2,000 ($1,000 automatic credit + extra $500 for health screening + extra $500 for tobacco-free test or program; must agree to share results with testing agency)

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
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 and beyond covered at 10% coinsurance, no deductible.
	Specialist visit	20% coinsurance*	20% coinsurance*	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractic and acupuncture*	20% coinsurance for chiropractic and acupuncture*	Visits 1-5 covered at 10% coinsurance, in-network and out-of-network. Visits 6 and beyond covered at 20% coinsurance. Preauthorization is required for 6th visit and beyond for chiropractic and acupuncture.
	Select preventive care/screening/immunization	No charge	No charge	Free if included on list of free preventive services.
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——————

*The annual out-of-pocket maximum limits how much you pay each year toward coinsurance. If you reach the annual out-of-pocket maximum ($2,400/single coverage or $4,800/family coverage), the HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket maximum **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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic drugs	15% for retail; 10% for mail order*	15% for retail; not applicable for mail order*	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	25% for retail; 20% for mail order*	25% for retail; not applicable for mail order*	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	25% for retail; 20% for mail order*	25% for retail; not applicable for mail order*	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.
	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*	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	20% coinsurance*	20% coinsurance*	——————none——————

*The annual out-of-pocket maximum limits how much you pay each year toward coinsurance. If you reach the annual out-of-pocket maximum ($2,400/single coverage or $4,800/family coverage), the HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket maximum **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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance*	20% coinsurance*	——————none——————
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	——————none——————
	Urgent care	10% coinsurance*	10% coinsurance*	Visits 1-4 covered as primary care at 100%, in and out of network. Visits 5 and beyond covered at 10% coinsurance, no deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	20% coinsurance*	Preauthorization required; $300 penalty if you fail to notify Anthem.
	Physician/surgeon fee	20% coinsurance*	20% coinsurance*	——————none——————
If you have mental health, behavioral health, or substance abuse needs Benefits administered by Beacon Health Options	Mental/behavioral health outpatient services	10% coinsurance*	10% coinsurance*	No deductible required. Includes day treatment and intensive outpatient (IOP).
	Mental/behavioral health inpatient services	20% coinsurance*	20% coinsurance*	Preauthorization required; $300 penalty if you fail to notify Beacon Health Options within 48 hours.
	Substance use disorder outpatient services	10% coinsurance*	10% coinsurance*	No deductible required. Includes day treatment and intensive outpatient (IOP).
	Substance use disorder inpatient services	20% coinsurance*	20% coinsurance*	Preauthorization required; $300 penalty if you fail to notify Beacon Health Options within 48 hours.

*The annual out-of-pocket maximum limits how much you pay each year toward coinsurance. If you reach the annual out-of-pocket maximum ($2,400/single coverage or $4,800/family coverage), the HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket maximum **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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	No charge	Office visits covered at 100%. Diagnostics/X-rays/labwork covered separately.
	Delivery and all inpatient services	20% coinsurance*	20% coinsurance*	$300 penalty if preauthorization is not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	20% coinsurance*	Preauthorization required. $300 penalty if you fail to obtain preauthorization; may result in non-coverage or reduced coverage.
	Rehabilitation services	20% coinsurance*	20% coinsurance*	Visits 1-5 covered at 10% coinsurance, in-network and out-of-network. Visits 6 and beyond covered at 20% coinsurance, in-network and out-of-network. Preauthorization required for 25th visit and beyond for all services.
	Habilitation services	20% coinsurance*	20% coinsurance*	Preauthorization required for 25th visit and beyond for all services.
	Skilled nursing care	20% coinsurance*	20% coinsurance*	Preauthorization required; $300 penalty if you fail to obtain preauthorization; may result in non-coverage or reduced coverage.
	Durable medical equipment	20% coinsurance*	20% coinsurance*	Failure to obtain preauthorization may result in non-coverage or reduced coverage for purchases or cumulative rentals over $1,000.
	Hospice service	No charge	No charge	Preauthorization required; $300 penalty if you fail to obtain preauthorization; may result in non-coverage or reduced coverage.

*The annual out-of-pocket maximum limits how much you pay each year toward coinsurance. If you reach the annual out-of-pocket maximum ($2,400/single coverage or $4,800/family coverage), the HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket maximum **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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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:

If you lose coverage under the plan, then, depending upon the circumstances, federal and state laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-964-0530. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa,** or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310
Telephone: 1-800-964-0530
Website: **www.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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Assumptions:

- Family HAP coverage
- Maximum $2,000 Health Account credits

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,670
- **Health Account pays:** $1,870
- **Patient pays:** $0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays (before Health Account):

Deductibles	$1,000
Copays	$0
Coinsurance	$870
Limits or exclusions	$0
Total	**$1,870**

Patient pays (after Health Account):

Health Account credits	$2,000
Health Account reimbursements	$1,870
Leftover Health Account balance	$130
Total patient payment	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,120
- **Health Account pays:** $1,280
- **Patient pays:** $0

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays (before Health Account):

Deductibles	$1,000
Copays	$0
Coinsurance	$280
Limits or exclusions	$0
Total	**$1,280**

Patient pays (after Health Account):

Health Account credits	$2,000
Health Account reimbursements	$1,280
Leftover Health Account balance	$720
Total patient payment	**$0**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.