



2017 Medical Plan Comparison Chart for Retirees and Surviving Dependents Non-Medicare-Eligible Members

This chart provides an overview of benefits available to non-Medicare-eligible participants.

For benefits administered by Anthem Blue Cross, Beacon Health Options, Express Scripts or Kaiser Permanente, the information contained in applicable service provider agreements between PG&E and Anthem Blue Cross, Beacon Health Options, Express Scripts or Kaiser Permanente shall govern in case of conflict between this chart and the service provider agreement. For the Blue Shield and Health Net plans, the information about the plans contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the plan or service provider shall govern in case of conflict between this chart and the EOC or service provider agreement.

ACRONYMS AT A GLANCE

ASHN: American Specialty Health Network	HMO: Health Maintenance Organization
EOC: Evidence of Coverage	MHSA: Mental Health and Substance Abuse
EPO: Exclusive Provider Organization	PCP: Primary Care Physician
IPA: Independent Physicians Association or Independent Practice Association	



Medical Benefits

PROVISIONS	A		B		C		D		E		F		G	
	NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross		COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross		RETIREE OPTIONAL PLAN (ROP) Administered by Anthem Blue Cross		BLUE SHIELD HMO		HEALTH NET HMO		KAISER PERMANENTE EPO NORTH & SOUTH			
	Network	Non-Network												
General	Care provided by network providers Annual deductible: • \$120/person; \$240/two people; \$320/three or more people Annual out-of-pocket maximum (includes deductible): • \$750/person; \$1,500/two or more people No lifetime benefit maximum No pre-existing condition exclusions	Care provided by non-network providers Annual deductible: • \$240/person; \$480/two people; \$680/three or more people Annual out-of-pocket maximum (includes deductible): • \$1,000/person; \$2,000/two or more people No lifetime benefit maximum No pre-existing condition exclusions	May use provider of choice (may experience savings with network providers) Annual deductible: • \$120/person; \$240/two people; \$320/three or more people Annual out-of-pocket maximum (includes deductible): • \$750/person; \$1,500/two or more people No lifetime benefit maximum No pre-existing condition exclusions		May use provider of choice (may experience savings with network providers) Annual deductible: • \$400/person; no more than \$1,200/family Annual out-of-pocket maximum (includes deductible): • \$4,000/person; no more than \$8,000/family No lifetime benefits maximum No pre-existing condition exclusions		Must use Blue Shield HMO network providers No annual deductible No annual out-of-pocket maximum No lifetime benefit maximum No pre-existing condition exclusions		Must use providers affiliated with Health Net HMO No annual deductible Annual out-of-pocket maximum: • \$1,500/person; \$4,500/three or more people (excludes prescription drugs) No lifetime benefit maximum No pre-existing condition exclusions		Must use Kaiser Permanente facilities and doctors No annual deductible Annual out-of-pocket maximum: • \$1,500/person; \$3,000/two or more people (excludes prescription drugs and infertility services) No lifetime benefit maximum No pre-existing condition exclusions			
	Network benefits and limits may not be combined with non-network benefits and limits													
	All Anthem Blue Cross-administered plan benefits and out-of-pocket maximums are based on Eligible Expenses only*													
Routine Preventive Care	• Primary care—\$10 copay/visit • Specialist—\$20 copay/visit • Lab/X-ray covered separately	70%	• Primary care—\$10 copay/visit • Specialist—\$20 copay/visit • Lab/X-ray covered separately		70%		\$10 copay/visit according to health plan schedule		\$10 copay/visit for Basic Periodic Health Evaluation		\$10 copay/visit			
Office Visits, Urgent Care	• Primary care—\$10 copay/visit • Specialist (including OB/GYN)—\$20 copay/visit • Lab/X-ray covered separately	70%	• Primary care—\$10 copay/visit • Specialist (including OB/GYN)—\$20 copay/visit • Lab/X-ray covered separately		70%		• \$10 copay/office, home or urgent care visit Office visits: • \$30 copay/visit without referral (Access+ Specialist)—must be in the same Medical Group or IPA		• \$10 copay/office, home or urgent care visit		• \$10 copay/office or urgent care visit • No charge/home visit			
Prescription Drugs	See Prescription Drug Benefits chart for details													
Immunizations and Injections	95%	70%	95%		70%		• Immunizations (age 18 and older)—no charge • Allergy injections included in office visit • Allergy serum purchased separately for treatment—no charge		• Immunizations—no charge • Allergy testing, allergy injections and allergy serum—no charge		• \$10 copay/visit for allergy testing • \$5 copay/visit for allergy injection • No charge for immunizations			
Chiropractic Care	80% for care approved by ASHN	70% for up to 15 visits for medically necessary care	80% for medically necessary care only; preauthorization by ASHN required after initial visit		70%; 10-visit maximum per year		Discounts available; contact Member Services for details		Discounts available; contact Member Services for details		\$10 copay/visit; self-referral allowed; no preauthorization needed			
Acupuncture	80% for up to 20 visits/year from licensed acupuncturist or M.D.	70% for up to 15 visits/year from licensed acupuncturist or M.D.	80% for up to 20 visits/year from licensed acupuncturist or M.D.		70%; 10-visit maximum per year		Discounts available; contact Member Services for details		Discounts available; contact Member Services for details		\$10 copay/visit; referral required from a Kaiser physician			
X-Rays and Lab Tests	90%	70%	90%		70%		No charge		No charge		No charge			
Outpatient Physical Therapy	80%	70%	80%		70%		\$10 copay/visit; provided as long as continued treatment is medically necessary pursuant to the treatment plan		\$10 copay/visit		\$10 copay/visit; therapy is given if, in the judgment of a plan physician, significant improvement is achievable			
Outpatient Hospital	\$35 copay/visit; waived if admitted; lab/X-ray covered separately	70%	\$35 copay/visit; waived if admitted; lab/X-ray covered separately		70%		\$10 copay/visit		\$10 copay/visit		• \$10 copay/procedure for outpatient surgery • \$10 copay/visit for all other outpatient services			
Hospital Stay	100% after \$100 copay; preauthorization required for non-emergency care, \$300 penalty if not obtained; covers semi-private room (private if medically necessary)	70%; preauthorization required for non-emergency care, \$300 penalty if not obtained; covers semi-private room (private if medically necessary)	100% after \$100 copay; preauthorization required for non-emergency care, \$300 penalty if not obtained; covers semi-private room (private if medically necessary)		70%; preauthorization required for non-emergency care, \$250 penalty if not obtained; covers semi-private room (private if medically necessary)		No charge		No charge		No charge			
Skilled Nursing Facility	90% for semi-private room after three days in hospital; preauthorization required, \$300 penalty if not obtained; excludes custodial care	70% for semi-private room after three days in hospital; preauthorization required, \$300 penalty if not obtained; excludes custodial care	90% for semi-private room after three days in hospital; preauthorization required, \$300 penalty if not obtained; excludes custodial care		70% for semi-private room after three days in hospital; preauthorization required; excludes custodial care		No charge; 100-day limit; excludes custodial care; prior hospital stay may be required		No charge; 100-day limit; excludes custodial care		No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician; not covered for members living outside of service area; excludes custodial care			
Home Health Care	90%; preauthorization required, \$300 penalty if not obtained; excludes custodial care	70%; preauthorization required, \$300 penalty if not obtained; excludes custodial care	90%; preauthorization required, \$300 penalty if not obtained; excludes custodial care		70%; preauthorization required; excludes custodial care		No charge; 100 visits/calendar year		No charge; no day limit		No charge to members in service area when prescribed by a plan physician; 100-day limit/calendar year; not covered for members living outside of service area			
Hospice Care	90%; preauthorization required, \$300 penalty if not obtained; excludes custodial care	70%; preauthorization required, \$300 penalty if not obtained; excludes custodial care	90%; preauthorization required, \$300 penalty if not obtained; excludes custodial care		70%; preauthorization required; excludes custodial care		No charge		No charge		No charge to members in service area when prescribed by a plan physician; not covered for members living outside of service area			
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rentals over \$1,000; \$300 penalty if not obtained	70%; preauthorization required for purchase or cumulative rentals over \$1,000; \$300 penalty if not obtained	80%; preauthorization required for purchase or cumulative rentals over \$1,000; \$300 penalty if not obtained		70%		No charge; preauthorization required; see plan EOC for limitations and exclusions		No charge; preauthorization required; see plan EOC for limitations and exclusions		No charge to members in service area when prescribed by a plan physician; limitations and exclusions apply; not covered for members living outside of service area			
Hearing Aids	80%; 1 per ear every 3 years	80%; 1 per ear every 3 years	80%; 1 per ear every 3 years		80%; 1 per ear every 3 years		100% up to \$2,000 every 2 years or 80% of total allowable cost every 3 years, whichever is greater		80%; 1 per ear every 3 years		80%; 1 per ear every 3 years			
Emergency Room	\$35 copay/visit; waived if admitted; lab/X-ray covered separately	\$35 copay/visit; waived if admitted; lab/X-ray covered separately	\$35 copay/visit; waived if admitted; lab/X-ray covered separately		70%		\$25 copay/visit for emergencies (waived if admitted); must contact PCP within 24 hours		\$25 copay/visit for emergencies (waived if admitted); must notify Health Net within 48 hours		\$25 copay/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)			
Mental Health and Substance Abuse (MHSA)	See the Mental Health and Substance Abuse (MHSA) Benefits chart for details													

*Eligible Expenses are: (1) expenses for health services that are covered by the plan; (2) those that Anthem Blue Cross considers "medically necessary" for the diagnosis or treatment of an illness or injury; and (3) those that do not exceed the "reasonable and customary" rate as determined by Anthem Blue Cross. Any costs not meeting this definition are the responsibility of the member. Call Anthem Blue Cross Member Services for more information.

2017 Medical Plan Comparison Chart for Retirees and Surviving Dependents Non-Medicare-Eligible Members

The information in this chart is intended as a high-level summary of prescription drug benefits for non-Medicare-eligible plan members.

Network Access Plan (NAP), Comprehensive Access Plan (CAP) and Retiree Optional Plan (ROP)

- Express Scripts administers prescription drug benefits for the NAP, CAP and ROP:
- The ROP has an annual deductible that is separate from your medical plan deductible. In addition, for all Anthem-administered plans, your prescription drug annual out-of-pocket maximums are separate from your medical plan out-of-pocket maximums.
 - Some drugs may require special authorization from Express Scripts. If you have questions, contact Express Scripts by calling the member services number listed on your Express Scripts ID card or visit www.express-scripts.com.

Blue Shield, Health Net and Kaiser Permanente

These plans provide retail and mail-order prescription drug coverage for their members, not Express Scripts. For specific information about your plan's drug coverage, contact your plan directly.



Prescription Drug Benefits

PROVISIONS	A		C	D	E	F	G
	NETWORK ACCESS PLAN (NAP)						
	Network	Non-Network					
General	Retail and mail-order prescription drugs are administered by Express Scripts					Retail and mail-order prescription drugs are administered by the plans	
Annual Prescription Drug Deductible <small>Separate from medical plan annual deductible</small>	None			<ul style="list-style-type: none"> \$200/person for retail and mail-order combined No family maximum 	None	None	None
Annual Prescription Drug Out-of-Pocket Maximum <small>Separate from medical plan annual out-of-pocket maximum</small>	For retail and mail-order combined: <ul style="list-style-type: none"> \$500/person No more than \$1,000/family 			For retail and mail-order combined: <ul style="list-style-type: none"> \$1,500/person No more than \$3,000/family 	None	None	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None						
Retail Purchases	First three 30-day fills of maintenance drugs and all 30-day fills of non-maintenance drugs At participating pharmacy: <ul style="list-style-type: none"> 85% for generic 75% for brand You pay extra 5% coinsurance for 4th refill and beyond of maintenance drugs Generic Incentive Provision applies*			Plan pays 60%	For up to a 30-day supply—you pay: <ul style="list-style-type: none"> \$5/generic formulary \$15/brand formulary \$35/non-formulary Open formulary Some drugs require preauthorization	For up to a 30-day supply—you pay: <ul style="list-style-type: none"> \$5/generic formulary \$15/brand formulary \$35/non-formulary Open formulary Some drugs require preauthorization	You pay \$10 for up to a 100-day supply when obtained at a plan pharmacy Closed formulary
Mail-Order Purchases	Plan pays: <ul style="list-style-type: none"> 100% for drugs on Express Scripts' Low-Cost Generic List Generic Incentive Provision applies*		All other drugs: <ul style="list-style-type: none"> 90% for generic 80% for brand 	Plan pays: <ul style="list-style-type: none"> 100% for drugs on Express Scripts' Low-Cost Generic List All other drugs: <ul style="list-style-type: none"> 70% for 90-day supply 	For up to a 90-day supply—you pay: <ul style="list-style-type: none"> \$10/generic formulary \$30/brand formulary \$70/non-formulary Open formulary Exceptions may apply for specialty drugs	For up to a 90-day supply—you pay: <ul style="list-style-type: none"> \$10/generic formulary \$30/brand formulary \$70/non-formulary No annual maximum Open formulary	You pay \$10 for up to a 100-day supply Closed formulary
Infertility, Sexual Dysfunction, Memory Enhancement and Contraceptive Drugs	Plan pays 50% for retail and mail-order, unless medically necessary Medically necessary drugs are covered at standard reimbursement rates Generic Incentive Provision applies*			Plan pays 50%	Call Blue Shield for details	Call Health Net for details	Up to a 100-day supply; you pay \$10 for contraceptives and other specialty drugs; 50% for infertility and sexual dysfunction drugs. Memory enhancement drugs not covered.

*Generic Incentive Provision: If you purchase a brand-name drug when a generic is available, you'll be responsible for paying the price difference plus any required coinsurance. **Note:** Any generic/brand price differential you pay is a non-covered expense and therefore does not count toward your out-of-pocket maximum.



Mental Health and Substance Abuse (MHSA) Benefits

The following chart provides an overview of mental health and substance abuse (MHSA) benefits for non-Medicare-eligible plan members. If you're enrolled in the NAP or CAP, your MHSA benefits are administered by Beacon Health Options. If you're enrolled in the ROP, your MHSA benefits are administered by Anthem Blue Cross. If you're enrolled in Blue Shield, Health Net or Kaiser Permanente, your MHSA benefits are administered by both your plan and by Beacon Health Options, depending on the type of care you receive.

When care is provided by Beacon Health Options:

- All inpatient and alternative levels of care must be medically necessary.
- Care that is not medically necessary will not be covered.

PROVISIONS	A		C	D	E	F	G
	NETWORK ACCESS PLAN (NAP) <small>Administered by Beacon Health Options</small>						
	Network	Non-Network					
General	Each plan's general medical plan provisions listed on the Medical Benefits chart also apply to MHSA benefits. Your medical and MHSA expenses are combined when determining deductibles and out-of-pocket maximums.*						
Applied Behavioral Analysis (ABA)	Covered at 100% through Beacon Health Options; requires preauthorization by Beacon Health Options; no deductible and no limits.						May use Beacon Health Options (preauthorization required) or Kaiser. Covered at 100%; no deductible and no limits.
Outpatient Mental Health	<ul style="list-style-type: none"> No charge for initial visit to psychiatrist for medication evaluation \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	<ul style="list-style-type: none"> 70% of usual and customary charges No visit limit 	<ul style="list-style-type: none"> No charge for initial visit to psychiatrist for medication evaluation \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	<ul style="list-style-type: none"> 70% after deductible No visit limit 	<ul style="list-style-type: none"> \$10 copay/visit No visit limit 	<ul style="list-style-type: none"> \$10 copay/visit No visit limit 	<ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit
Inpatient Mental Health	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 100% after deductible \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 70% of usual and customary charges \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 100% after deductible \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Anthem Blue Cross <ul style="list-style-type: none"> 70% after deductible \$250 penalty if you fail to preauthorize No limit on number of stays 	<ul style="list-style-type: none"> No charge No limit on number of stays 	<ul style="list-style-type: none"> No charge No limit on number of stays 	<ul style="list-style-type: none"> No charge No limit on number of stays
Outpatient Substance Abuse	<ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	<ul style="list-style-type: none"> 70% of usual and customary charges No visit limit 	<ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	<ul style="list-style-type: none"> 70% after deductible No visit limit 	Coverage through Beacon Health Options network only, not HMO: <ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	Coverage through Health Net or Beacon Health Options: <ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No visit limit 	Coverage through Kaiser: <ul style="list-style-type: none"> \$10 copay/visit (individual) \$5 copay/visit (group) No day limit
Inpatient Substance Abuse	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 100% after deductible \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 70% of usual and customary charges \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Beacon Health Options <ul style="list-style-type: none"> 100% after deductible \$300 penalty if you fail to notify within 48 hours No limit on number of stays 	Requires preauthorization by Anthem Blue Cross <ul style="list-style-type: none"> 70% after deductible \$250 penalty if you fail to preauthorize No limit on number of stays 	Coverage through Beacon Health Options network only, not HMO. Requires preauthorization by Beacon Health Options. <ul style="list-style-type: none"> 100% No limit on number of stays 	Coverage through Health Net or Beacon Health Options. Beacon Health Options treatment requires preauthorization by Beacon Health Options. <ul style="list-style-type: none"> 100% No limit on number of stays 	May use Beacon Health Options or Kaiser for detoxification. All other residential inpatient treatment is available through Beacon Health Options network only, not Kaiser. All Beacon Health Options treatment—including residential inpatient treatment—requires preauthorization; \$300 penalty if you fail to notify Beacon Health Options within 48 hours <ul style="list-style-type: none"> 100% No limit on number of stays

*Eligible Expenses are: (1) expenses for health services that are covered by the plan; (2) those that the claims administrator considers "medically necessary" for diagnosis or treatment; and (3) those that do not exceed the "usual and customary" rate as determined by the claims administrator. Any costs not meeting this definition are the responsibility of the member. For more information or if you have questions, contact the claims administrator for your plan: Beacon Health Options, Anthem Blue Cross, Kaiser Permanente or your HMO, as listed in this chart.