2012 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), Retiree Optional Plan (ROP) and HSA Medical Plan

Medco Health administers prescription drug benefits for the NAP, CAP, ROP and HSA Medical Plan:

- The ROP has an annual deductible that is separate from your medical plan deductible. In addition, for all Anthem-administered plans except the HSA Medical Plan, 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 Medco Health to ensure that they are medically necessary and used appropriately, as determined by the FDA and manufacturer.
- Manufacturer rebates are earned when participants purchase certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as plan sponsor, has with Medco Health. These rebates are received from Medco Health approximately six months after the end of the contract quarter in which the drug was purchased and are deposited back to the trust holding the plan's assets. The cost of the plan is reduced by the value of the rebates, which in turn reduces participants' contributions.

For specific information about Medco Health prescription drug coverage, call Medco Health's Member Services department directly or visit its website at www.medcohealth.com.

Health Maintenance Organizations (HMOs)

The HMOs provide retail and mail-order prescription drug coverage for their members, not Medco Health. For specific information about HMO drug coverage, contact the HMO directly.

Prescription Drug Benefits

PROVISIONS	A NETWORK ACCESS PLAN (NAP) Network	B NETWORK ACCESS PLAN (NAP) Non-Network	C COMPREHENSIVE ACCESS PLAN (CAP)	D RETIREE OPTIONAL PLAN (ROP)	E HSA MEDICAL PLAN IN-AREA Network	F HSA MEDICAL PLAN IN-AREA Non-Network	G HSA MEDICAL PLAN OUT-OF-AREA	H BLUE SHIELD HMO	I HEALTH NET HMO	J KAISER PERMANENTE HMO NORTH & SOUTH
General	Retail and mail-order prescription drugs are administered by Medco Health				Retail and mail-order prescription drugs are administered by Medco Health			Retail and mail-order prescription drugs are administered by the HMOs		
Annual Prescription Drug Deductible Separate from medical plan annual deductible except for HSA Medical Plan	None			• $200/person for retail and mail-order, combined • No family maximum	Prescription drug benefits are subject to a combined medical and prescription drug deductible under the HSA Medical Plan (see Medical Benefits chart)			None	None	None
Annual Prescription Drug Out-of-Pocket Maximum Separate from medical plan annual out-of-pocket maximum except for HSA Medical Plan	For retail and mail-order combined: • $500/person • No more than $1,000/family			For retail and mail-order combined: • $1,500/person • No more than $3,000/family	Prescription drug benefits are subject to a combined medical and prescription drug network out-of-pocket maximum under the HSA Medical Plan (see Medical Benefits chart)			None	None	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None				None			None		
Retail Purchases	First three 30-day fills at a participating pharmacy—plan pays: • 85% for generic • 75% for brand Refills of maintenance drugs beyond three 30-day fills and coverage at non-participating pharmacies—plan pays: • 80% for generic • 70% for brand Generic Incentive Provision applies*			Plan pays 60%	Plan pays: • 100% (no deductible required) for preventive prescriptions** • 90% after deductible for non-preventive prescriptions** ** Drugs filled at non-network pharmacies will be filled at average negotiated network rate; 15% cost penalty for retail refill of maintenance drugs on 4th fill; Generic Incentive Provision* and step therapy provision apply Penalties and charges above average negotiated network rate do not apply toward deductible and out-of-pocket maximum			For up to a 30-day supply—you pay: • $5/generic formulary • $15/brand formulary • $35/non-formulary Open formulary Some drugs require pre-authorization	For up to a 30-day supply—you pay: • $5/generic formulary • $15/brand formulary • $35/non-formulary Open formulary Some drugs require pre-authorization	You pay $10 for up to a 100-day supply when obtained at a plan pharmacy Closed formulary
Mail-Order Purchases	Plan pays: • 100% for drugs on Medco Low-Cost Generic List All other drugs: • 90% for generic • 80% for brand Generic Incentive Provision applies*			Plan pays: • 100% for drugs on Medco Low-Cost Generic List All other drugs: • 70% for 90-day-supply	Plan pays: • 100% (no deductible required) for preventive prescriptions • 90% after deductible for non-preventive prescriptions Generic Incentive Provision* and step therapy provision apply			For up to a 90-day supply—you pay: • $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: • $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%	• Contraceptives covered at 100% • Other drugs covered at regular plan reimbursements only if medically necessary			Call Blue Shield for details	Call Health Net for details	Call Kaiser Permanente for details

*** 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 annual deductible or out-of-pocket maximum. Drugs listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision.

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 ValueOptions. If you're enrolled in the ROP or HSA Medical Plan, your MHSA benefits are administered by Anthem Blue Cross. If you're enrolled in an HMO, your MHSA benefits are administered by both your HMO and by ValueOptions, depending on the type of care you receive.

When care is provided by ValueOptions:

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

Mental Health and Substance Abuse (MHSA) Benefits

PROVISIONS	A NETWORK ACCESS PLAN (NAP) Administered by ValueOptions Network	B NETWORK ACCESS PLAN (NAP) Administered by ValueOptions Non-Network	C COMPREHENSIVE ACCESS PLAN (CAP) Administered by ValueOptions	D RETIREE OPTIONAL PLAN (ROP) Administered by Anthem Blue Cross	E HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Network	F HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Non-Network	G HSA MEDICAL PLAN OUT-OF-AREA Administered by Anthem Blue Cross	H BLUE SHIELD HMO	I HEALTH NET HMO	J KAISER PERMANENTE HMO NORTH & SOUTH
								Must use HMO referral and authorization process		
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.*									
Outpatient Mental Health	• No charge for initial visit to psychiatrist for medication evaluation • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	• 70% of usual and customary charges • No visit limit	• No charge for initial visit to psychiatrist for medication evaluation • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	• 70% after deductible • No visit limit	• 90% after deductible • No visit limit	• 70% after deductible • No visit limit	• 90% after deductible • No visit limit	• $10 copay/visit • No visit limit	• $10 copay/visit • No visit limit	• $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit
Inpatient Mental Health	Requires pre-authorization by ValueOptions • 100% after deductible • $300 penalty if you fail to pre-authorize • No limit on number of stays	Requires pre-authorization by ValueOptions • 70% of usual and customary charges • $300 penalty if you fail to pre-authorize • No limit on number of stays	Requires pre-authorization by ValueOptions • 100% after deductible • $300 penalty if you fail to pre-authorize • No limit on number of stays	• 70% after deductible • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 90% • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 70% • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 90% • No limit on number of stays	• No charge • No limit on number of stays	• No charge • No limit on number of stays	• No charge • No limit on number of stays
Outpatient Substance Abuse	• $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	• 70% of usual and customary charges • No visit limit	• $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	• 70% after deductible • No visit limit	• 90% • No visit limit	• 70% • No visit limit	• 90% after deductible • No visit limit	Coverage through ValueOptions network only, not HMO: • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	Coverage through ValueOptions network only, not HMO: • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	Coverage through Kaiser: • $10 copay/visit (individual) • $5 copay/visit (group) • No day limit
Inpatient Substance Abuse	Requires pre-authorization by ValueOptions • 100% after deductible • $300 penalty if you fail to pre-authorize • No limit on number of stays	Requires pre-authorization by ValueOptions • 70% of usual and customary charges • $300 penalty if you fail to pre-authorize • No limit on number of stays	Requires pre-authorization by ValueOptions • 100% after deductible • $300 penalty if you fail to pre-authorize • No limit on number of stays	• 70% after deductible • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 90% • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 70% • No limit on number of stays	Requires pre-authorization by Anthem Blue Cross • 90% • No limit on number of stays	Coverage through ValueOptions network only, not HMO. Requires pre-authorization by ValueOptions. • 100% • No limit on number of stays	Coverage through ValueOptions network only, not HMO. Requires pre-authorization by ValueOptions. • 100% • No limit on number of stays	• Intensive Outpatient Program and Partial Hospitalization Program covered by Kaiser—no charge. Coverage for inpatient substance abuse, detoxification and residential treatment through ValueOptions network only, not Kaiser. Requires pre-authorization by ValueOptions. • 100% • No limit on number of stays

*** Eligible Expenses are:** (1) expenses for covered 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: ValueOptions, Anthem Blue Cross or your HMO, as listed in this chart.

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2012 Medical Plan Comparison Chart for

Retirees and Surviving Dependents Non-Medicare-Eligible Members

Medical Benefits

This chart provides an overview of benefits available to non-Medicare-eligible participants. For benefits administered by Anthem Blue Cross, ValueOptions or Medco, the information contained in applicable service provider agreements between PG&E and Anthem Blue Cross, ValueOptions or Medco shall govern in case of conflict between this chart and the service provider agreement. For HMO plans, the information about the HMOs contained in an applicable Evidence of Coverage (EOC) or service provider agreement between PG&E and the HMO 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
- **EOC:** Evidence of Coverage
- **FDA:** Food and Drug Administration
- **IPA:** Independent Physicians Association or Independent Practice Association
- **HMO:** Health Maintenance Organization
- **MHSA:** Mental Health and Substance Abuse
- **PCP:** Primary Care Physician
- **PPO:** Preferred Provider Organization

PROVISIONS	A NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross Network	B NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross Non-Network	C COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross	D RETIREE OPTIONAL PLAN (ROP) Administered by Anthem Blue Cross	E HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Network	F HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Non-Network	G HSA MEDICAL PLAN OUT-OF-AREA Administered by Anthem Blue Cross	H BLUE SHIELD HMO	I HEALTH NET HMO	J KAISER PERMANENTE HMO NORTH & SOUTH
								Must use HMO referral and authorization process		
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** Network benefits and limits may not be combined with non-network benefits and limits	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**	Care provided by network providers **Annual deductible:** • $1,250/person; $2,500/two or more people Same deductible applies to eligible network and non-network expenses **Annual out-of-pocket maximum (includes deductible):** • $1,750/person; $3,500/two or more people **No lifetime benefit maximum** **No pre-existing condition exclusions** Network benefits and limits may not be combined with non-network benefits and limits	Care provided by non-network providers **Annual out-of-pocket maximum (includes deductible):** • $2,750/person; $5,500/two or more people **No lifetime benefit maximum** **No pre-existing condition exclusions**	May use any licensed provider **Annual deductible:** • $1,250/person; $2,500/two or more people **Annual out-of-pocket maximum (includes deductible):** • $1,750/person; $3,500/two or more people **No lifetime benefit 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**
	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%	100% for physician services, lab and X-ray, and immunizations (not subject to deductible)	70% (subject to deductible)	100% for physician services, lab and X-ray, and immunizations (not subject to deductible)	$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	70%	• Primary care—$10 copay/visit • Specialist (including OB/GYN)—$20 copay/visit	70%	90% for primary, specialist and urgent care visits (subject to deductible)	70% for primary, specialist and urgent care visits (subject to deductible)	90% for primary, specialist and urgent care visits (subject to deductible)	• $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				HSA Medical Plan deductible and out-of-pocket maximum apply to prescription drugs (see Prescription Drug Benefits chart for details)			See Prescription Drug Benefits chart for details	See Prescription Drug Benefits chart for details	See Prescription Drug Benefits chart for details
Immunizations and Injections	95%	70%	95%	70%	90% (100% for disease prevention immunizations)	70% (90% for disease prevention immunizations)	90% (100% for disease prevention immunizations)	• 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 using ASHN provider	70% for up to 15 visits for medically necessary care	80% for medically necessary care only; pre-authorization by ASHN required after initial visit	70%, 10-visit maximum per year	90% for up to 20 visits/year	70% for up to 15 visits/year	90% for up to 20 visits/year	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details
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%	90% 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.	90% for up to 20 visits/year from licensed acupuncturist or M.D.	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details
X-Rays and Lab Tests	90%	70%	90%	70%	90% (100% if part of preventive care)	70% (90% if part of preventive care)	90% (100% if part of preventive care)	No charge	No charge	No charge
Outpatient Physical Therapy	80%	70%	80%	70%	90%	70%	90%	$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%	90% (100% if part of preventive care)	70%	90% (100% if part of preventive care)	$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; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if medically necessary)	70%; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if medically necessary)	100% after $100 copay; pre-authorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if medically necessary)	70%; pre-authorization required for non-emergency care, $250 penalty if not obtained; covers semi-private room (private if medically necessary)	90% for semi-private room (private if medically necessary); includes intensive care; pre-authorization required for non-emergency care	70% for semi-private room (private if medically necessary); includes intensive care; pre-authorization required for non-emergency care	90% for semi-private room (private if medically necessary); includes intensive care; pre-authorization required for non-emergency care	No charge	No charge	No charge
Skilled Nursing Facility	90% for semi-private room after three days in hospital; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70% for semi-private room after three days in hospital; pre-authorization required, $300 penalty if not obtained; excludes custodial care	90% for semi-private room after three days in hospital; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70% for semi-private room after three days in hospital; excludes custodial care	90% for semi-private room after three days in hospital; excludes custodial care; pre-authorization required	70% for semi-private room after three days in hospital; excludes custodial care; pre-authorization required	90% for semi-private room after three days in hospital; excludes custodial care; pre-authorization required	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%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	90%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70%; pre-authorization required; excludes custodial care	90%; pre-authorization required; excludes custodial care	70%; pre-authorization required; excludes custodial care	90%; pre-authorization 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%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	90%; pre-authorization required, $300 penalty if not obtained; excludes custodial care	70%; pre-authorization required; excludes custodial care	90%; pre-authorization required; excludes custodial care	70%; pre-authorization required; excludes custodial care	90%; pre-authorization 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%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	70%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	80%; pre-authorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	70%	90%; pre-authorization required for purchase or cumulative rental over $1,000	70%; pre-authorization required for purchase or cumulative rental over $1,000	90%; pre-authorization required for purchase or cumulative rental over $1,000	No charge; pre-authorization required; see plan EOC for limitations and exclusions	No charge; pre-authorization required; see plan EOC for limitations and exclusions	No charge to members in service area when prescribed by a plan physician; see EOC for limitations and exclusions; not covered for members living outside of service area
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%	90% for medical emergency	90% for medical emergency; 70% for non-emergencies	90% for medical emergency	$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 covered 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.

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