2010 Medical Plan Comparison Chart

For IBEW, ESC and SEIU Represented Employees

Medical Benefits

This chart provides an overview of medical plan benefits. For plans administered by Anthem Blue Cross, the information contained in applicable service provider agreements between PG&E and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement. For HMO plans, the information about the HMOs or the insured products 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.

PROVISIONS	NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross		COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross	BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH AND SOUTH
	Network	***Non-Network***				
General	Care provided by network providers **Annual deductible:** • $100/person; no more than $300/family **Annual out-of-pocket maximum (includes deductible):** • $750/person; no more than $1,500/family **No lifetime benefit maximum** **No pre-existing condition exclusions**	Care provided by non-network providers **Annual deductible:** • $200/person; no more than $600/family **Annual out-of-pocket maximum (includes deductible):** • $1,000/person; no more than $2,000/family **No lifetime benefit maximum** **No pre-existing condition exclusions**	May use provider of choice (may experience savings with network providers) **Annual deductible:** • $100/person; no more than $300/family **Annual out-of-pocket maximum (includes deductible):** • $750/person; no more than $1,500/family **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; no more than $4,500/family (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; no more than $3,000/family (excludes prescription drugs) **No lifetime benefit maximum** **No pre-existing condition exclusions**
	• All plan benefits and out-of-pocket maximums are based on Eligible Expenses only* • Network benefits and limits may not be combined with non-network benefits and limits		All plan benefits and out-of-pocket maximums are based on Eligible Expenses only*			
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)	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	No charge; 100-day limit; excludes custodial care	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
Emergency Room Care	$35 copay/visit; waived if admitted	$35 copay/visit; waived if admitted	$35 copay/visit; waived if admitted	$25 copay/visit for emergencies (waived if admitted); must contact PCP within 24 hours	$25 copay/visit for emergencies (waived if admitted); must notify PCP within 48 hours	$25 copay/visit for emergencies (waived if admitted directly to the hospital within 24 hours for the same condition)
Outpatient Hospital Care	$35 copay/visit; waived if admitted	70% for outpatient surgery	$35 copay/visit; waived if admitted	$10 copay/visit	$10 copay/visit	$10 copay/procedure for outpatient surgery; $10 copay/visit for all other outpatient services
Maternity Care	Covered as any other condition; pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section); $300 penalty if not obtained	Covered as any other condition; pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section); $300 penalty if not obtained	Covered as any other condition; pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section); $300 penalty if not obtained	No charge	No charge	No charge
Well-Baby Care	Covered as any other condition	Covered as any other condition	Covered as any other condition	$10 copay/visit	$10 copay/visit	$10 copay/visit
Office Visits	• 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	• $10 copay/office visit; $30 copay/visit without referral (Access+ Specialist) — must be in the same Medical Group or IPA • $10 copay/home visit	• $10 copay/office visit • $10 copay/home visit	$10 copay/office visit No charge/home visit
Urgent Care Visits	• 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	$10 copay/visit	$10 copay/visit	$10 copay/visit
Routine Physical Examinations	• 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	$10 copay/visit according to health plan schedule	$10 copay/visit for basic Periodic Health Evaluation	$10 copay/visit
Immunizations and Injections	95%	70%	95%	• Immunizations (age 18 and older) — no charge • Allergy injections included in office visit • Allergy serum purchased separately for treatment — no charge	• Immunizations (age 18 and older) — no charge • Allergy testing, allergy injections and allergy serum — no charge	• Immunizations — no charge • $10 copay/visit allergy testing if no office visit • $5 copay/visit for allergy injections if no office visit; allergy serum not sold separately
Eye Examinations	Not covered	Not covered	Not covered	$10 copay/visit for screening; lenses and frames not covered	$10 copay/visit for screening; lenses and frames not covered	$10 copay/visit for screening/refraction; lenses and frames not covered
X-Rays and Lab Tests	90%	70%	90%	No charge	No charge	No charge
Pre-Admission Testing	95%	70%	95%	No charge	No charge	No charge
Home Health Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	90%; requires prior authorization, $300 penalty if not obtained; 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
Hospice Care	90%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	70%; requires prior authorization, $300 penalty if not obtained; excludes custodial care	90%; requires prior authorization, $300 penalty if not obtained; 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
Outpatient Physical Therapy	80%	70%	80%	$10 copay/visit; provided as long as continued treatment is medically necessary pursuant to the treatment plan	$10 copay/visit; provided as long as significant improvement is expected	$10 copay/visit; therapy is given if, in the judgment of a plan physician, significant improvement is achievable
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	No charge; pre-authorization required; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions	No charge to members in service area when prescribed by a plan physician; see plan EOC for limitations and exclusions; not covered for members living outside of service area
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	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 per year from licensed acupuncturist or M.D.	70% for up to 15 visits per year from licensed acupuncturist or M.D.	80% for up to 20 visits per 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
Other Benefits	Infertility — paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	Infertility — paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	Infertility — Paid according to type of benefit; $7,000 lifetime maximum; balances from prior plans carry forward	Hearing exams when performed by a physician or by an audiologist at the request of a physician — $10 copay/visit	Hearing exams — $10 copay/visit	Hearing exams — $10 copay/visit

***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.*

Prescription Drug Benefits

The information in this chart is intended as a high-level summary of prescription drug benefits.

Network Access Plan (NAP) and Comprehensive Access Plan (CAP)

Medco Health administers prescription drug benefits for the NAP and CAP. Please note:

- The NAP and CAP plans have annual prescription drug out-of-pocket maximums that are separate from your medical plan and MH&AD 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 returned to the company. The cost of the plan is reduced by the value of the rebates, which in turn reduces participants' premium contributions.

For specific information about Medco Health prescription drug coverage, call Medco Health's Member Services department directly, or visit its Web site 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 your HMO drug coverage, contact your HMO directly (contact information is listed on page 20 of the *Guide*).

PROVISIONS	NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross	COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross	BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH AND SOUTH
General	Retail and mail-order prescription drugs are administered by Medco		Retail and mail-order prescription drugs are administered by the HMO		
Annual Prescription Drug Deductible Separate from medical plan annual deductible	None		None	None	None
Annual Prescription Drug Out-of-Pocket Maximum	For retail and mail-order combined: • $500/person • No more than $1,000/family		None	None	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None		None	None	None
Retail Purchases	1st three 30-day supplies at a participating pharmacy — plan pays: • 85% for generic • 75% for brand Refills beyond 90 days and coverage at non-participating pharmacies — plan pays: • 80% for generic • 70% for brand *Generic Incentive Provision applies**		Up to 30-day supply — you pay: • $5/generic formulary • $15/brand formulary • $35/non-formulary *Open formulary* *Some drugs require pre-authorization*	Up to 30-day supply — you pay: • $5/generic formulary • $15/brand formulary • $35/non-formulary *Open formulary* *Some drugs require pre-authorization*	You pay $10/up to 100-day supply when obtained at a plan pharmacy *Closed formulary*
Mail-Order Purchases	Plan pays: • 90% for generic • 80% for brand *Generic Incentive Provision applies**		For up to 90-day supply — you pay: • $10/generic formulary • $30/brand formulary • $70/non-formulary *Open formulary*	For up to 90-day supply — you pay: • $10/generic formulary • $30/brand formulary • $70/non-formulary *Open formulary*	You pay $10/up to 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**		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 out-of-pocket maximum. Drugs listed on Medco Health's "Narrow Therapeutic List" will be excluded from this mandatory generic provision.*

Mental Health and Alcohol and Drug Care (MH&AD) Benefits

The following chart provides an overview of mental health, alcohol and drug care (MH&AD) benefits. If you are enrolled in NAP or CAP, your mental health, alcohol and drug care benefits are administered by ValueOptions. If you are enrolled in an HMO, they are administered both by your HMO and ValueOptions, depending on the type of care you receive.

When care is provided by **ValueOptions:**

- Pre-authorization is required for inpatient and hospital stays; you must obtain it within 48 hours of the start of treatment. Care that is not authorized by ValueOptions within 48 hours but that is medically necessary is subject to a $300 pre-authorization penalty. Care that is not medically necessary will not be covered.

PROVISIONS	NETWORK ACCESS PLAN (NAP) COMPREHENSIVE ACCESS PLAN (CAP)		BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH AND SOUTH
	ValueOptions-Administered Network Benefits	***ValueOptions-Administered Non-Network Benefits (NAP members only)***			
General	• General provisions for MH&AD benefits are separate from the medical plan and prescription drug provisions • Network benefits and limits may not be combined with non-network benefits and limits • All plan benefits and out-of-pocket maximums are based on Eligible Expenses only* Members enrolled in the Comprehensive Access Plan (CAP) can use any licensed provider; their Eligible Expenses will be covered at the network level of benefits.		Each plan's general medical plan provisions listed on the Medical Plan Comparison Chart also apply to MH&AD benefits		
	Annual deductible: • $100/person • No more than $300/family **Annual out-of-pocket maximum:** • $750/person • No more than $1,500/family **No lifetime benefit limit, no pre-existing exclusions**	**Annual deductible:** • $200/person • No more than $600/family **Annual out-of-pocket maximum:** • $1,000/person • No more than $2,000/family **No lifetime benefit limit, no pre-existing exclusions**			
Outpatient Mental Health	*Requires referral by ValueOptions* • 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	$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	No charge; no day limit	No charge; no day limit	No charge; no day limit
Outpatient Alcohol and Drug Care	*Requires referral by ValueOptions* • 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	**Coverage through ValueOptions, not HMO; requires referral by ValueOptions* • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	**Coverage through ValueOptions, not HMO; requires referral by ValueOptions* • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit	*Coverage through Kaiser* • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit
Inpatient Alcohol and Drug Care	*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	**Coverage through ValueOptions, not HMO; requires pre-authorization by ValueOptions* • 100% • $300 penalty if you fail to pre-authorize • No limit on number of stays	**Coverage through ValueOptions, not HMO; requires pre-authorization by ValueOptions* • 100% • $300 penalty if you fail to pre-authorize • No limit on number of stays	• Detoxification covered by Kaiser — no charge **Coverage through ValueOptions, not HMO* • Inpatient and residential services covered *when pre-authorized by ValueOptions* — no charge • $300 penalty if you fail to pre-authorize • No limit on number of stays

***Eligible Expenses are:** (1) expenses for Covered Health Services that are covered by the plan; (2) those that ValueOptions considers "Medically Necessary" for diagnosis or treatment; and (3) those that do not exceed the "Usual and Customary" rate as determined by Value Options. Any costs not meeting this definition are the responsibility of the member. For additional information or questions, call ValueOptions.*