

2011 Medical Plan Comparison Chart for IBEW, ESC and SEIU Represented Employees

This chart provides an overview of medical plan benefits. 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 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.

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
PCP:	Primary Care Physician
PPO:	Preferred Provider Organization

Medical Benefits

PROVISIONS	NETWORK ACCESS PLAN (NAP) Administered by Anthem Blue Cross		COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross	HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross		HSA MEDICAL PLAN OUT-OF-AREA Administered by Anthem Blue Cross	BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH & SOUTH
	Network	Non-Network		Network	Non-Network		Must use HMO referral and authorization process	Must use providers affiliated with Health Net HMO	Must use Kaiser Permanente facilities and doctors
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	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	Care provided by non-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): • \$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 HMO referral and authorization process 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) 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	100% for physician services, lab and X-ray, and immunizations (not subject to deductible)	70% (subject to deductible)	100% for physician services and any accompanying lab and X-ray (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	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%	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 (age 18 and older)—no charge • Allergy testing, allergy injections and allergy serum—no charge	• \$10 copay/visit for allergy testing if no office visit • \$5 copay/visit for allergy injections if no office visit; allergy serum not sold separately
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	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
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	Covered as any other condition	Covered as any other condition	Covered as any other condition	No charge	No charge	No charge
X-Rays and Lab Tests	90%	70%	90%	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%	90%	70%	90%	\$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
Outpatient Hospital	\$35 copay/visit; waived if admitted	70%	\$35 copay/visit; waived if admitted	90% (100% if part of preventive care)	70%	90%	\$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)	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	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	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%; 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	90%; excludes custodial care; pre-authorization required	70%; excludes custodial care; pre-authorization required	90%; excludes custodial care; pre-authorization required	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	90%; excludes custodial care; pre-authorization required	70%; excludes custodial care; pre-authorization required	90%; excludes custodial care; pre-authorization required	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	90%	70%	90%	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 EOC for limitations and exclusions; not covered for members living outside of service area
Emergency Room	\$35 copay/visit; waived if admitted	\$35 copay/visit; waived if admitted	\$35 copay/visit; waived if admitted	90% for medical emergency	90% for medical emergency	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, Alcohol and Drug Care (MH&AD)	See the Mental Health, Alcohol and Drug Care (MH&AD) 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.



2011 Medical Plan Comparison Chart for IBEW, ESC and SEIU Represented Employees

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

Network Access Plan (NAP), Comprehensive Access Plan (CAP) and HSA Medical Plan

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

- 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 your HMO drug coverage, contact your HMO directly (contact information is listed in the *Benefits Enrollment Guide*).

Prescription Drug Benefits

PROVISIONS	NETWORK ACCESS PLAN (NAP)		COMPREHENSIVE ACCESS PLAN (CAP)	HSA MEDICAL PLAN IN-AREA		HSA MEDICAL PLAN OUT-OF-AREA	BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH & SOUTH	
	Network	Non-Network		Network	Non-Network					
General	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 <i>Separate from medical plan annual deductible except for HSA Medical Plan</i>	None			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 <i>Separate from medical plan annual out-of-pocket maximum except for HSA Medical Plan</i>	For retail and mail-order combined: • \$500/person • No more than \$1,000/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									
Retail Purchases	First three 30-day fills at a participating pharmacy—plan pays: • 85% for generic • 75% for brand Refills 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: • 100% [no deductible required] for preventive prescriptions** • 90% after deductible for non-preventive prescriptions ** <i>Drugs filled at non-network pharmacies will be filled at average negotiated network rate</i> <i>15% cost penalty for retail refill of maintenance drugs on 4th fill; Generic Incentive Provision* and step therapy provision apply</i> <i>Penalties and charges above average negotiated network rate do not apply toward deductible and out-of-pocket maximum</i>			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% [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	For up to a 90-day supply—you pay: • \$10/generic formulary • \$30/brand formulary • \$70/non-formulary 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*			• 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.

This chart provides an overview of mental health, alcohol, and drug care (MH&AD) benefits. If you're enrolled in the NAP or CAP, your MH&AD benefits are administered by ValueOptions. If you're enrolled in the HSA Medical Plan, your MH&AD benefits are administered by Anthem Blue Cross. If you're enrolled in an HMO, your MH&AD 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, Alcohol and Drug Care (MH&AD) Benefits

PROVISIONS	NETWORK ACCESS PLAN (NAP) <i>Administered by ValueOptions</i>		COMPREHENSIVE ACCESS PLAN (CAP) <i>Administered by ValueOptions</i>	HSA MEDICAL PLAN IN-AREA <i>Administered by ValueOptions</i>		HSA MEDICAL PLAN OUT-OF-AREA <i>Administered by Anthem Blue Cross</i>	BLUE SHIELD HMO	HEALTH NET HMO	KAISER PERMANENTE HMO NORTH & SOUTH
	Network	Non-Network		Network	Non-Network				
General	Each plan's general medical plan provisions listed in the Medical Benefits chart also apply to MH&AD benefits. Your medical, mental health, and alcohol & drug care 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	90%	70%	90%	• \$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	Requires pre-authorization by Anthem Blue Cross • 90%	Requires pre-authorization by Anthem Blue Cross • 70%	Requires pre-authorization by Anthem Blue Cross • 90%	No charge; no day limit	No charge; no day limit	No charge; no day limit
Outpatient Alcohol and Drug Care	• \$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	90%	70%	90%	Coverage through ValueOptions network only, not HMO: • \$10 copay/visit (individual) • \$5 copay/visit (group)	Coverage through ValueOptions network only, not HMO: • \$10 copay/visit (individual) • \$5 copay/visit (group)	Coverage through Kaiser: • \$10 copay/visit (individual) • \$5 copay/visit (group)
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	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 Anthem Blue Cross • 90%	Requires pre-authorization by Anthem Blue Cross • 70%	Requires pre-authorization by Anthem Blue Cross • 90%	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	• Detoxification only covered by Kaiser—no charge All other coverage through ValueOptions network only, not HMO. 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.