2013 Medical Plan Comparison Chart for
IBEW, ESC and SEIU Represented Employees

This chart provides an overview of medical plan benefits. The information contained in applicable service provider agreements between PG&E and Anthem Blue Cross, Kaiser Permanente, ValueOptions or Express Scripts shall govern in case of conflict between this chart and the service provider agreement.

ACRONYMS AT A GLANCE

ASHN: American Specialty Health Network
EPO: Exclusive Provider Organization
MHSA: Mental Health and Substance Abuse
PCP: Primary Care Physician
PPO: Preferred Provider Organization

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	**HSA MEDICAL PLAN IN-AREA** Administered by Anthem Blue Cross		**HSA MEDICAL PLAN OUT-OF-AREA** Administered by Anthem Blue Cross	**KAISER PERMANENTE EPO NORTH & SOUTH**
	Network	**Non-Network**		**Network**	**Non-Network**		**Must use Kaiser's 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**	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 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 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			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)	• 90% after deductible for lab, X-ray, and immunizations • 70% after deductible for all other routine preventive care	100% for physician services, lab and X-ray, and immunizations (not subject to deductible)	$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	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 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
Immunizations and Injections	95%	70%	95%	90% (100% for disease prevention immunizations)	70% (90% for disease prevention immunizations)	90% (100% for disease prevention immunizations)	• No charge for immunizations • $10 copay/visit for allergy testing • $5 copay/visit for allergy injection
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	90% for up to 20 visits/year	70% for up to 15 visits/year	90% for up to 20 visits/year	$10 copay/visit; preauthorization required; self-referral not allowed
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.	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.	$10 copay/visit; preauthorization required; self-referral not allowed
Maternity Care	Covered as any other condition; preauthorization 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; preauthorization 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; preauthorization 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; preauthorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section)	Covered as any other condition; preauthorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section)	Covered as any other condition; preauthorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section)	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
Outpatient Physical Therapy	80%	70%	80%	90%	70%	90%	$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	90% (100% if part of preventive care)	70%	90% (100% if part of preventive care)	$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)	90% for semi-private room (private if medically necessary); includes intensive care; preauthorization required for non-emergency care	70% for semi-private room (private if medically necessary); includes intensive care; preauthorization required for non-emergency care	90% for semi-private room (private if medically necessary); includes intensive care; preauthorization required for non-emergency care	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	90% for semi-private room after three days in hospital; excludes custodial care; preauthorization required	70% for semi-private room after three days in hospital; excludes custodial care; preauthorization required	90% for semi-private room after three days in hospital; excludes custodial care; preauthorization required	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	90%; preauthorization required; excludes custodial care	70%; preauthorization required; excludes custodial care	90%; preauthorization required; excludes custodial care	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	90%; preauthorization required; excludes custodial care	70%; preauthorization required; excludes custodial care	90%; preauthorization required; excludes custodial care	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 rental over $1,000; $300 penalty if not obtained	70%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	80%; preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained	90%; preauthorization required for purchase or cumulative rental over $1,000	70%; preauthorization required for purchase or cumulative rental over $1,000	90%; preauthorization required for purchase or cumulative rental over $1,000	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
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	90% for medical emergency	90% for medical emergency; 70% for non-emergencies	90% for medical emergency	$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.

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2013 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

Express Scripts (merged with Medco) 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 Express Scripts. If you have questions, contact Express Scripts by calling the member services number listed on your Medco ID card or visit www.express-scripts.com. Your Medco contact information will continue to work with Express Scripts.

Kaiser Permanente

Kaiser Permanente provides retail and mail-order prescription drug coverage for its members, not Express Scripts. For specific information about your drug coverage, contact Kaiser directly.

Prescription Drug Benefits

PROVISIONS	A NETWORK ACCESS PLAN (NAP) Network	B NETWORK ACCESS PLAN (NAP) Non-Network	C COMPREHENSIVE ACCESS PLAN (CAP)	D HSA MEDICAL PLAN IN-AREA Network	E HSA MEDICAL PLAN IN-AREA Non-Network	F HSA MEDICAL PLAN OUT-OF-AREA	G KAISER PERMANENTE EPO NORTH & SOUTH
General	Retail and mail-order prescription drugs are administered by Express Scripts						Retail and mail-order prescription drugs are administered by Kaiser Permanente
Annual Prescription Drug Deductible Separate from medical plan annual deductible except for HSA Medical Plan	None			Prescription drug benefits are subject to a combined medical and prescription drug deductible under the HSA Medical Plan (see Medical Benefits chart)			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			Prescription drug benefits are subject to a combined medical and prescription drug out-of-pocket maximum under the HSA Medical Plan (see Medical Benefits chart)			None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None			None			None
Retail Purchases	First three 30-day fills of maintenance drugs and all 30-day fills of non-maintenance drugs **At participating pharmacy:** • 85% for generic • 75% for brand **At non-participating pharmacy:** • 80% for generic • 70% for brand You pay extra 5% coinsurance for 4th refill and beyond of maintenance drugs Generic Incentive Provision applies*			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 applies* Penalties and charges above average negotiated network rate do not apply toward deductible and out-of-pocket maximum			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 Express Scripts' Low-Cost Generic List Generic Incentive Provision applies* All other drugs: • 90% for generic • 80% for brand			Plan pays: • 100% (no deductible required) for preventive prescriptions • 90% after deductible for non-preventive prescriptions Generic Incentive Provision applies*			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			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 annual deductible (if applicable) or out-of-pocket maximum. Drugs listed on Express Scripts' "Narrow Therapeutic List" will be excluded from this mandatory generic provision.

Mental Health and Substance Abuse (MHSA) Benefits

This chart provides an overview of mental health and substance abuse (MHSA) benefits. If you're enrolled in the NAP or CAP, your MHSA benefits are administered by ValueOptions. If you're enrolled in the HSA Medical Plan, your MHSA benefits are administered by Anthem Blue Cross. If you're enrolled in Kaiser Permanente, your MHSA benefits are administered by both Kaiser Permanente and 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.

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 HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Network	E HSA MEDICAL PLAN IN-AREA Administered by Anthem Blue Cross Non-Network	F HSA MEDICAL PLAN OUT-OF-AREA Administered by Anthem Blue Cross	G KAISER PERMANENTE EPO NORTH & SOUTH
General	Each plan's general medical plan provisions listed in the Medical Benefits chart also apply to MHSA benefits. Your medical and MHSA expenses are combined when determining deductibles and out-of-pocket maximums.*						Must use Kaiser's referral and authorization process
Applied Behavioral Analysis (ABA)	Covered at 100% through ValueOptions; no deductible and no limits.						May use ValueOptions or Kaiser. Covered at 100%; no deductible and no limits.
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% after deductible; no visit limit	70% after deductible; no visit limit	90% after deductible; no visit limit	• $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit
Inpatient Mental Health	Requires preauthorization by ValueOptions • 100% after deductible • $300 penalty if you fail to notify within 48 hours • No limit on number of stays	Requires preauthorization by ValueOptions • 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 ValueOptions • 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 • 90% after deductible • No limit on number of stays	Requires preauthorization by Anthem Blue Cross • 70% after deductible • No limit on number of stays	Requires preauthorization by Anthem Blue Cross • 90% after deductible • No limit on number of stays	No charge; no day limit
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	90% after deductible; no visit limit	70% after deductible; no visit limit	90% after deductible; no visit limit	Coverage through Kaiser: • $10 copay/visit (individual) • $5 copay/visit (group) • No visit limit
Inpatient Substance Abuse	Requires preauthorization by ValueOptions • 100% after deductible • $300 penalty if you fail to notify within 48 hours • No limit on number of stays	Requires preauthorization by ValueOptions • 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 ValueOptions • 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 • 90% after deductible • No limit on number of stays	Requires preauthorization by Anthem Blue Cross • 70% after deductible • No limit on number of stays	Requires preauthorization by Anthem Blue Cross • 90% after deductible • No limit on number of stays	May use Kaiser or ValueOptions for detoxification. All other residential inpatient treatment is available through ValueOptions network only, not Kaiser. All ValueOptions treatment requires preauthorization. • 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 additional information or if you have questions, contact the claims administrator for your plan: ValueOptions, Anthem Blue Cross, or Kaiser Permanente, as listed in this chart.