



2023 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

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| ASHN: American Specialty Health Network | HMO: Health Maintenance Organization |
| EOC: Evidence of Coverage | MHSUD: Mental Health and Substance Use Disorder |
| 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 | | | | | | | Must use your plan'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 | | 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* | | | | | | | | | | | | | |
| Telehealth | 24/7 access to a doctor through Anthem's telehealth program, LiveHealth Online: \$10 copay/visit | | | | 24/7 access to a doctor through Anthem LiveHealth Online: Plan pays 70% | | | | Available through Teladoc for \$5 copay. You also may use Anthem LiveHealth Online; you pay \$59/visit. | | You may receive in-person or telemedicine services from network provider; you pay \$10/visit. You also may use Anthem LiveHealth Online; you pay \$59/visit. | | No charge through Kaiser. You also may use Anthem LiveHealth Online; you pay \$59/visit. | |
| 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% | • 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% | • 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 | | 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 | | 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 | | 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%; preauthorization required for advanced imaging procedures; no coverage if not obtained. Call Anthem at the number on your ID card for details. | 70%; preauthorization required for advanced imaging procedures; no coverage if not obtained. Call Anthem at the number on your ID card for details. | 90%; preauthorization required for advanced imaging procedures; no coverage if not obtained. Call Anthem at the number on your ID card for details. | | 70%; preauthorization required for advanced imaging procedures; no coverage if not obtained. Call Anthem at the number on your ID card for details. | No charge | | 70%; preauthorization required for advanced imaging procedures; no coverage if not obtained. Call Anthem at the number on your ID card for details. | 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 | | 70% | \$10 copay/visit | | \$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 for outpatient surgery; waived if admitted; lab/X-ray covered separately | 70% | \$35 copay for outpatient surgery; waived if admitted; lab/X-ray covered separately | | 70% | \$10 copay/visit | | 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 | | 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 | | 70% for semi-private room after three days in hospital; preauthorization required; 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 | |
| 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 | | 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 | | 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 | | 70% | No charge; preauthorization required; see plan EOC for limitations and exclusions | | No charge; preauthorization may apply; 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 | | 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 | |
| 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 | | 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 Use Disorder (MHSUD) | See the Mental Health and Substance Use Disorder (MHSUD) 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 maximum allowed amount 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.

2023 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 [express-scripts.com/pgeretiree](https://www.express-scripts.com/pgeretiree).

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 | | B | C | D | E | F | G | | | | | | |
|--|---|-------------|---|---|--|---|--|---|--|--|--|--|--|--|
| | NETWORK ACCESS PLAN (NAP) | | | | | | | | | | | | | |
| | Network | Non-Network | | | | | | | | | | | | |
| General | Retail and mail-order prescription drugs are administered by Express Scripts | | | | | | | | | | | | | |
| Annual Prescription Drug Deductible Separate from medical plan annual deductible | None | | | | | | | | | | | | | |
| Annual Prescription Drug Out-of-Pocket Maximum Separate from medical plan annual out-of-pocket maximum | 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"> \$200/person for retail and mail-order combined No family maximum | | 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* | | | | At non-participating pharmacy: <ul style="list-style-type: none"> 80% for generic 70% for brand | | 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 and Contraceptive Drugs | Plan pays 50% for retail and mail-order Generic Incentive Provision applies* | | | | Plan pays 50% for retail and mail-order | | 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. | | | |

* **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 Use Disorder (MHSUD) Benefits



The following chart provides an overview of mental health and substance use disorder (MHSUD) benefits for non-Medicare-eligible plan members. If you're enrolled in the NAP or CAP, your MHSUD benefits are administered by Beacon Health Options. If you're enrolled in the ROP, your MHSUD benefits are administered by Anthem Blue Cross, except for ABA benefits, which are administered by Beacon Health Options. If you're enrolled in Blue Shield, Health Net or Kaiser Permanente, your MHSUD 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 | | B | C | D | E | F | G | | | | | | |
|--|--|-------------|---|---|--|--|---|--|---|---|---|--|---|--|
| | NETWORK ACCESS PLAN (NAP) Administered by Beacon Health Options | | | | | | | | | | | | | |
| | Network | Non-Network | | | | | | | | | | | | |
| General | Each plan's general medical plan provisions listed on the Medical Benefits chart also apply to MHSUD benefits. Your medical and MHSUD expenses are combined when determining deductibles and out-of-pocket maximums.* | | | | | | | | | | | | | |
| Telehealth | Access to a psychiatrist or counselor through Anthem LiveHealth Online: <ul style="list-style-type: none"> Anthem NAP, CAP and ROP: You pay the same cost as for in-network outpatient mental health visits. | | | | | Available through Teladoc. You also may use Anthem LiveHealth Online; you pay the full cost. | | You may receive in-person service from network provider; you pay \$10/visit. You also may use Anthem LiveHealth Online; you pay the full cost. | | No charge through Kaiser. You also may use Anthem LiveHealth Online; you pay the full cost. | | | | |
| Applied Behavioral Analysis (ABA) | Covered at 100% through Beacon Health Options; requires preauthorization by Beacon Health Options; 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 (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 | | | |
| Outpatient Substance Use Disorder | <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 Use Disorder | 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. All substance use treatment requires preauthorization. <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 maximum allowed amount 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.