



# 2015 Medical Plan Comparison Chart for Retirees and Surviving Dependents Medicare-Eligible Members

This chart provides an overview of benefits available to Medicare-eligible participants. For benefits administered by Anthem Blue Cross, ValueOptions or Express Scripts, the information contained in applicable service provider agreements between PG&E and Anthem Blue Cross, ValueOptions or Express Scripts 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
COB:	Coordination of Benefits
EOC:	Evidence of Coverage
IPA:	Independent Physicians Association or Independent Practice Association
HMO:	Health Maintenance Organization
MHSA:	Mental Health and Substance Abuse
PCP:	Primary Care Physician

## Medical Benefits

PROVISIONS	<b>A</b> COMPREHENSIVE ACCESS PLAN (CAP) Administered by Anthem Blue Cross	<b>B</b> PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) Administered by Anthem Blue Cross	<b>C</b> RETIREE OPTIONAL PLAN (ROP) Administered by Anthem Blue Cross	<b>D</b> BLUE SHIELD MEDICARE COB HMO	<b>E</b> HEALTH NET MEDICARE COB HMO	<b>F</b> HEALTH NET SENIORITY PLUS (Medicare Advantage HMO)	<b>G</b> KAISER PERMANENTE SENIOR ADVANTAGE NORTH & SOUTH (Medicare Advantage HMO)
General	May use provider of choice <b>Annual deductible:</b> • \$120/person; \$240/two people; \$320/three or more people <b>Annual out-of-pocket maximum (includes deductible):</b> • \$750/person; \$1,500/two or more people <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>	Available to all Medicare-eligible retirees and their Medicare-eligible dependents (if retiree elects Medicare Supplemental Plan and dependent does not have Medicare, dependent will be enrolled in appropriate Anthem Blue Cross-administered medical plan) <b>Annual deductible:</b> • \$100/person <b>No annual out-of-pocket maximum</b> <b>Lifetime benefit maximum:</b> • \$10,000/person; up to \$1,000 restored each year <b>No pre-existing condition exclusions</b>	May use provider of choice <b>Annual deductible:</b> • \$400/person; no more than \$1,200/family <b>Annual out-of-pocket maximum (includes deductible):</b> • \$4,000/person; no more than \$8,000/family <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>	<b>Must use HMO referral and authorization process</b> Must use Blue Shield HMO network providers <b>No annual deductible</b> <b>No annual out-of-pocket maximum</b> <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>	Must use providers affiliated with Health Net HMO <b>No annual deductible</b> <b>Annual out-of-pocket maximum:</b> • \$1,500/person; \$4,500/three or more people (excludes prescription drugs) <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>	Must use providers affiliated with Health Net HMO <b>No annual deductible</b> <b>Annual out-of-pocket maximum:</b> • \$3,400/person (excludes Part D benefits, fitness dues and prescription drugs) <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>	Must use Kaiser Permanente facilities and doctors <b>No annual deductible</b> <b>Annual out-of-pocket maximum:</b> • \$1,500/person; \$3,000/two or more people (excludes prescription drugs and infertility services) <b>No lifetime benefit maximum</b> <b>No pre-existing condition exclusions</b>
	All 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	Not covered	70%	\$10 copay/visit according to health plan schedule	\$10 copay/visit for basic periodic health evaluation	No charge for periodic health evaluation	No charge
Office Visits, Urgent Care	• Primary care—\$10 copay/visit • Specialist (including OB/GYN)—\$20 copay/visit • Lab/X-ray covered separately	80% of eligible expenses after Medicare	70%	• \$10 copay/office, home or urgent care visit <b>Office visits:</b> • \$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, home or urgent care visit	<b>Office visits:</b> • \$10 copay/office visit • No charge/home visit <b>Urgent care:</b> • \$10 copay/visit at a Kaiser facility in area; \$25 copay/visit at non-Kaiser facility
Prescription Drugs	See Prescription Drug Benefits chart for details						
Immunizations and Injections	95%	Not covered	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	• Immunizations—no charge • Immunizations for foreign travel covered at 80% • Allergy testing and allergy injections—no charge for Medicare-covered services	• \$10 copay/visit for allergy testing • \$3 copay/visit for allergy injection • No charge for immunizations
Chiropractic Care	80% for medically necessary care only; pre-authorization by ASHN required after initial visit	80% of eligible expenses after Medicare; services must be medically necessary	70%; 10-visit maximum per year	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details	\$10 copay/visit for Medicare-approved chiropractic service	\$10 copay/visit; preauthorization required; self-referral not allowed
Acupuncture	80% for up to 20 visits/year from licensed acupuncturist or M.D.	Not covered	70%	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details	Discounts available; contact Member Services for details	\$10 copay/visit; preauthorization required; self-referral not allowed
X-Rays and Lab Tests	90%	80% of eligible expenses after Medicare	70%	No charge	No charge	No charge	No charge
Outpatient Physical Therapy	80%	80% of eligible expenses after Medicare	70%	\$10 copay/visit; as long as continued treatment is medically necessary pursuant to the treatment plan	\$10 copay/visit	No charge	\$10 copay/visit
Outpatient Hospital	\$35 copay/visit; waived if admitted; lab/X-ray covered separately	80% of eligible expenses after Medicare	70%	\$10 copay/visit	\$10 copay/visit	\$10 copay/visit	\$10 copay/procedure for outpatient surgery
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)	80% of eligible hospital expenses after Medicare	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	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	80% of member copay amount per Medicare from 21st to 100th day of confinement; 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	No charge; 100-day limit; no prior hospital stay required; excludes custodial care	No charge; 100-day limit per benefit period; no prior hospital stay required; excludes custodial care	No charge to members in service area for up to 100 days per benefit period when prescribed by a plan physician
Home Health Care	90%; preauthorization required; \$300 penalty if not obtained; excludes custodial care	80% of eligible expenses after Medicare; excludes custodial care	70%; preauthorization required; excludes custodial care	No charge; 100 visits/calendar year	No charge; no day limit	No charge; no day limit	No charge
Hospice Care	90%; preauthorization required; \$300 penalty if not obtained; excludes custodial care	80% of eligible expenses after Medicare; excludes custodial care	70%; preauthorization required; excludes custodial care	No charge	No charge	Covered by Medicare	No charge
Durable Medical Equipment	80%; preauthorization required for purchase or cumulative rentals over \$1,000; \$300 penalty if not obtained	80% of eligible expenses after Medicare	70%	No charge; preauthorization required; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions	No charge; see plan EOC for limitations and exclusions
Hearing Aids	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 or 80% of total allowable cost every 3 years, whichever is greater	80%; 1 per ear every 3 years	80%; 1 per ear every 3 years	100% up to \$1,000 per ear or 80% of total cost, whichever is greater; 1 per ear every 3 years.
Emergency Room	\$35 copay/visit; waived if admitted; lab/X-ray covered separately	80% of eligible expenses after Medicare	70%	\$25 copay/visit for emergencies (waived if admitted); member must contact PCP within 24 hours of service	\$25 copay/visit for emergencies (waived if admitted); must notify Health Net within 48 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 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.

# 2015 Medical Plan Comparison Chart for Retirees and Surviving Dependents Medicare-Eligible Members

## Prescription Drug Benefits

PROVISIONS	<b>A</b> COMPREHENSIVE ACCESS PLAN (CAP) Administered by Express Scripts	<b>B</b> PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) Administered by Express Scripts	<b>C</b> RETIREE OPTIONAL PLAN (ROP) Administered by Express Scripts	<b>D</b> BLUE SHIELD MEDICARE COB HMO	<b>E</b> HEALTH NET MEDICARE COB HMO Administered by SilverScript	<b>F</b> HEALTH NET SENIORITY PLUS (Medicare Advantage HMO)	<b>G</b> KAISER PERMANENTE SENIOR ADVANTAGE NORTH & SOUTH (Medicare Advantage HMO)
General	Retail and mail-order prescription drugs are administered by Express Scripts			All HMOs, except the Health Net Medicare COB HMO, administer retail and prescription drugs. All HMOs, including the Health Net Medicare COB HMO, are Medicare Part D plans.			
Annual Prescription Drug Deductible Separate from medical plan annual deductible	None	• \$100/person for retail and mail-order combined • No family maximum	• \$200/person for retail and mail-order combined • No family maximum	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	For retail and mail-order combined: • \$1,500/person • No more than \$3,000/family	None	None	None	None
Annual or Lifetime Prescription Drug Maximum Benefit Limit	None	Lifetime limit of \$10,000/person; up to \$1,000 restored each year (does not apply to drugs purchased before 2004)	None	None	None	None	None
Retail Purchases	First three 30-day fills of maintenance drugs and all 30-day fills of non-maintenance drugs <b>At participating pharmacy:</b> • 85% for generic • 75% for brand  You pay extra 5% coinsurance for 4th refill and beyond of maintenance drugs Generic Incentive Provision applies*	Plan pays 75% Generic Incentive Provision applies*	Plan pays 60%	<b>Medicare Part D plan</b> For up to a 30-day supply—you pay: • \$5/generic • \$15/brand formulary • \$35/non-formulary Open formulary No annual maximum Some drugs require preauthorization	<b>Medicare Part D plan</b> For up to a 30-day supply—you pay: • \$5/generic • \$15/brand formulary • \$35/non-formulary Open formulary No annual maximum Some drugs require preauthorization Exceptions may apply for self-injectable and specialty drugs	<b>Medicare Part D plan</b> For up to a 30-day supply—you pay: • \$5/generic • \$15/brand formulary • \$35/non-formulary Open formulary No annual maximum Some drugs require preauthorization Exceptions may apply for self-injectable and specialty drugs	<b>Medicare Part D plan</b> You pay \$10 for up to a 100-day supply Closed formulary
Mail-Order Purchases	Plan pays: • 100% for drugs on Express Scripts' Low-Cost Generic List All other drugs: • 90% for generic • 80% for brand Generic Incentive Provision applies*	Plan pays: • 100% for drugs on Express Scripts' Low-Cost Generic List All other drugs: • 80% Generic Incentive Provision applies*	Plan pays: • 100% for drugs on Express Scripts' Low-Cost Generic List All other drugs: • 70% for 90-day supply	<b>Medicare Part D plan</b> For up to a 90-day supply—you pay: • \$10/generic • \$30/brand formulary • \$70/non-formulary Open formulary No annual maximum	<b>Medicare Part D plan</b> For up to a 90-day supply—you pay: • \$10/generic • \$30/brand formulary • \$70/non-formulary Open formulary No annual maximum	<b>Medicare Part D plan</b> For up to a 90-day supply—you pay: • \$10/generic • \$30/brand formulary • \$70/non-formulary Open formulary No annual maximum	<b>Medicare Part D plan</b> You pay \$10 for up to a 100-day supply Closed formulary No annual maximum
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*	Covered only to treat serious medical conditions Generic Incentive Provision applies*	Plan pays 50%	Call Blue Shield for details	Call Health Net 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. 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 or out-of-pocket maximum (if applicable). Drugs listed on Express Scripts' "Narrow Therapeutic List" will be excluded from this mandatory generic provision.

The information in this chart is intended as a high-level summary of prescription drug benefits for Medicare-eligible plan members.

### Comprehensive Access Plan (CAP), Medicare Supplemental Plan (MSP) and Retiree Optional Plan (ROP)

Express Scripts administers prescription drug benefits for the CAP, MSP and ROP.

- Your MSP and ROP deductibles, your CAP and ROP annual out-of-pocket maximums, and your MSP lifetime maximum are separate from those found in your medical plan.
- 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 [www.express-scripts.com](http://www.express-scripts.com).

### Health Net Medicare COB HMO

SilverScript administers prescription drug benefits for the Health Net Medicare COB HMO. If you have questions about your prescription drug benefits, call the member services number listed on your SilverScript ID card.

### Health Maintenance Organizations (HMOs)

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

## Mental Health and Substance Abuse (MHSA) Benefits

PROVISIONS	<b>A</b> COMPREHENSIVE ACCESS PLAN (CAP) Administered by ValueOptions	<b>B</b> PG&E MEDICARE SUPPLEMENTAL PLAN (MSP) Administered by Anthem Blue Cross	<b>C</b> RETIREE OPTIONAL PLAN (ROP) Administered by Anthem Blue Cross	<b>D</b> BLUE SHIELD MEDICARE COB HMO	<b>E</b> HEALTH NET MEDICARE COB HMO	<b>F</b> HEALTH NET SENIORITY PLUS (Medicare Advantage HMO)	<b>G</b> KAISER PERMANENTE SENIOR ADVANTAGE NORTH & SOUTH (Medicare Advantage HMO)
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.*						
Applied Behavioral Analysis (ABA)	Covered at 100% through ValueOptions; requires preauthorization by ValueOptions; no deductible and no limits.						May use ValueOptions (preauthorization required) 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	Not covered	• 70% after deductible • No visit limit	• \$10 copay/visit • 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 preauthorization by ValueOptions • 100% after deductible • \$300 penalty if you fail to notify within 48 hours • No limit on number of stays	• 80% of eligible expenses after Medicare, after deductible • No limit on number of stays	Requires preauthorization by Anthem Blue Cross • 70% after deductible • \$250 penalty if you fail to preauthorize • 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	• No charge • No limit on number of stays
Outpatient Substance Abuse	• \$10 copay/visit (individual) • \$5 copay/visit (group) • No visit limit	Not covered	• 70% 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 Health Net or ValueOptions. Health Net coverage: \$10 copay/visit; no visit limit. ValueOptions coverage: • \$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 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	Not covered	Requires preauthorization by Anthem Blue Cross • 70% after deductible • \$250 penalty if you fail to preauthorize • No limit on number of stays	Coverage through ValueOptions network only, not HMO. Requires preauthorization by ValueOptions. • 100% • No limit on number of stays	Coverage through ValueOptions network only, not HMO. Requires preauthorization by ValueOptions. • 100% • No limit on number of stays	Coverage through Health Net or ValueOptions. Health Net coverage: 100%, unlimited days, for inpatient (includes detoxification). ValueOptions treatment requires preauthorization by ValueOptions: • 100% • No limit on number of stays	May use ValueOptions or Kaiser 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 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.

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.