LETTER AGREEMENT NO. 98-54-PGE

IBEW

PACIFIC GAS AND ELECTRIC COMPANY
INDUSTRIAL RELATIONS DEPARTMENT
2850 SHADELANDS DRIVE, SUITE 100
WALNUT CREEK, CALIFORNIA 94598
(510) 974-4282

INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS, AFL-CIO
LOCAL UNION 1245, I.B.E.W.
P.O. BOX 4790
WALNUT CREEK, CALIFORNIA 94596
(510) 933-6060

MEL BRADLEY, MANAGER OR
DAVID J. BERGMAN, CHIEF NEGOTIATOR

JACK MCNALLY, BUSINESS MANAGER

June 23, 1998

Local Union No. 1245
International Brotherhood of
Electrical Workers, AFL-CIO
P.O. Box 4790
Walnut Creek, CA 94598

Attention: Mr. Jack McNally, Business Manager

Gentlemen:

Company and IBEW Local 1245 have been very proactive in recent years addressing issues dealing with the dynamics of modern day health care delivery. In addressing these issues, the parties have tried to balance two very important factors, controlling health care costs and providing quality health care for employees, retirees and their dependents.

In April 1992, the parties agreed to the selection of Prudential HealthCare as the vendor for the PG&E Managed Care Point-Of-Service Plan (Point-Of-Service - POS, Preferred Provider Organization - PPO, Out-Of-Area - OOA) effective January 1, 1993. In late 1997, the Company and Union agreed to a joint study to evaluate Prudential's performance as our managed care vendor and to perform a comparative analysis of available vendors in the marketplace today. In doing so, the parties underwent a comprehensive six month RFP process involving five major healthcare vendors (including Prudential HealthCare).

After thorough review and analysis of the information provided through the RFP process and on-site visits by the parties to the customer services and claims facilities of the healthcare vendors under consideration, the Company proposes the following changes effective January 1, 1999:

MANAGED CARE VENDOR

The selection of United HealthCare as the Managed Care vendor (POS, PPO, OOA) replacing Prudential HealthCare and the administration of Exhibit Q and Exhibit C of the 1994 Medical, Dental and Vision Benefit Agreement subject to the following terms and conditions:

A. United HealthCare to provide PG&E with specific guarantees to substantiate their contract proposal.

B. Participants who elect to enroll in the PG&E Medical Plan will be placed in the appropriate POS, PPO, or OOA healthcare plan nationwide.

C. The reference to specialty care physicians in bullet item number 2 under access objectives and in the first paragraph on page 176 of Exhibit Q of the 1994 Medical, Dental and Vision Benefit Agreement shall be interpreted as specialty physicians of the following categories:
   - Obstetrics/Gynecology
   - General Surgery

D. The provisions of Exhibit Q and Exhibit C of the 1994 Medical, Dental and Vision Benefit Agreement shall be enforceable among the parties through Title 102 of the Operating, Maintenance and Construction Employees Agreement (Title 9 of the Office and Clerical Employees Agreement), effective January 1, 1997. The enforcement mechanism shall be a Business Manager's Grievance.

E. The bargained language of Exhibit Q prevails pertaining to network eligibility. Network expansions will be implemented only if there is adequate network capacity to service all PG&E members in a particular geographic area meeting the network access criteria as defined in Exhibit Q of the 1994 Medical, Dental and Vision Benefit Agreement. Company proposes that any disputes regarding the application of this criteria be referred for investigation and resolution by a joint Company-Union Committee comprised of representatives from IBEW Local 1245, and representatives from PG&E Company's Benefits and Industrial Relations departments.

F. Selection of United HealthCare as the vendor for the PG&E Managed Care Point-Of-Service Plan does not run concurrent with the term of the Medical, Dental and Vision Benefit Agreement. Any change in vendor will require agreement of both parties.

G. The Appeals procedures currently in place will apply. These procedures address certain specific appeals categories (denial of medical necessity; denial of referral; denial above UCR; and issues pertaining to out-of-area travel) and define the formal procedure through which member appeals will be administered (See Attachment A).

H. A transition plan will be developed and will include conditions such as pregnancy in the third trimester, hospitalizations on December 31, 1998, terminal cases and other conditions where a defined treatment plan exists and where disruption of treatment might be dangerous to the patient's health. The composition of these transition benefits will be reviewed by the parties. An expedited appeals procedure will be developed and implemented to resolve any member disputes regarding the application of the transition benefits. Any such appeals will be heard and resolved by an agreed to medical examiner on an expedited basis. Transition benefits and the expedited

appeals process shall also be available to members during open enrollment prior to the January 1, 1999, United HealthCare implementation. Transition benefits will continue subsequent to implementation.

I. Quarterly meetings will be held between PG&E, IBEW Local 1245 and United HealthCare, beginning the fourth Tuesday in July 1998. These meetings will initially be held on a more frequent basis as needed.

J. A senior contact individual with both PG&E and United HealthCare will be provided to IBEW Local 1245. Arrangements will be made to have a vendor representative be responsive to the Union regarding member concerns and issues raised by the Union. PG&E will be included in the communication process with the vendor in order to ensure appropriate and timely resolution of any issues identified.

K. In order to receive full network coverage for treatment by specialists a member must be referred by the Primary Care Physician. However, Company will require that United HealthCare allow for Primary Care Physicians to make specialty referrals in or out of the network with payment at in-network levels in order to ensure, where possible, specialty referrals within a 30 minute drive time from the member's residence. Under this approach Primary Care Physicians will refer to an in-network specialist if one is available within 30 minutes driving time from the member's residence. If an in-network specialist is not available, the Primary Care Physician will refer to an out-of-network specialist located within 30 minutes driving time from the member's residence, with payment at in-network levels. If there are no specialists available within this distance from the member's residence, the employee continues to be eligible for the in-network level of benefits and the Primary Care Physicians will refer the member to the nearest appropriate specialty care physician. Any member disputes regarding the application of this criteria will be resolved as described in item E. These criteria do not apply in the event of members being referred to Centers of Excellence.

L. Female members covered under this agreement may access care without referral for routine OB/GYN care from any obstetrician/gynecologist (OB/GYN) within United HealthCare's network. The OB/GYN must obtain authorization for hospitalization, surgery and high-intensity diagnostic procedures.

M. Members will be designated as in or out of the network once a year prior to open enrollment. Any network expansions occurring subsequent to this open enrollment period will not affect member's network status. In the event of a mid-year expansion, members will not be required to join the Managed Care Point-Of-Service Plan, but may elect to do so on a voluntary basis.

N. Members may recommend physicians for participation in the Managed Care Point-Of-Service network to the Joint Company-Union Committee described in Item E.

O. In the event that there is no network chiropractor available to members in a particular geographic area, the member may request authorization for a referral to an out-of-

network chiropractor. Any such referrals approved by the chiropractic vendor will be covered at the in-network level of benefit. Members may recommend chiropractors for participation in the chiropractic network to the Joint Company-Union Committee described in Item E.

P. The parties shall immediately convene to discuss a vendor change should United HealthCare change from its current medical plan model (individual contract with physician). Any change must be agreed to by the Company and Union.

Q. The member claim form displayed in Exhibit Q and Exhibit C of the 1994 Medical, Dental and Vision Benefit Agreement will be replaced with a claim form specific to United HealthCare.

All references to the Prudential plans in the 1994 PG&E/IBEW Medical, Dental and Vision Benefit Agreement will now reference the United HealthCare plans.

PBGH

The Pacific Business Group on Health (PBGH) negotiates HMO health plan rates on an annual basis for major corporations. The HMO health plan rates that are negotiated through this alliance are the most cost-effective rates available because the health plan rates quoted are based on the collective number of participants for all of the member companies rather than each individual company (i.e. rates for 500,000 participants vs. rates for 30,000 participants). Company will join the PBGH negotiating alliance beginning with the 1999 plan year. As agreed to last year with the PacifiCare HMO, the PBGH plan that most closely resembles PG&E's current HMO plans will be used. Any change in HMO plan design(s) requires Company and Union agreement, excluding vendor-initiated changes. (See Attachment B for the 1999 HMO plan designs.)

HMO VENDOR SELECTION

While a member of the PBGH negotiating alliance, HMO vendors may be re-examined every other year. Either party may request a vendor change. The request must be made by February 1st of the year prior to the effective year. Any vendor change must be agreed to by the Company and Union.

HMO GEOGRAPHIC COVERAGE

While a member of the PBGH negotiating alliance, the Company will expand any HMO it offers to all counties where the HMO product line is available (e.g. Lifeguard will be available in all areas that it is licensed to operate as compared to just PG&E-selected counties). Any voluntary change in PG&E's membership in the PBGH negotiating alliance requires Company-Union agreement.

JOINT COMMUNICATION

Company and Union will coordinate all communications regarding the new healthcare vendor and other 1999 Open Enrollment changes to ensure a smooth transition. Update meetings will be available to the parties on an as needed basis. A communication and transition plan will be developed by the parties.

INTERIM ACTIVITY

The parties shall continue the 94-53 activity reviewing medical, dental and vision issues. The Committee should meet at least quarterly. The parties will determine the appropriate means to monitor the effectiveness of the health care plans in place.

This letter agreement cancels and supersedes Letter Agreement R3-92-43-PGE. All references to Letter Agreement R3-92-43-PGE in Exhibit Q and Exhibit C of the 1994 Medical, Dental and Vision Benefit Agreement shall now reference this letter agreement.

Except as otherwise provided, the changes will have an effective date of January 1, 1999, and will be incorporated in the Open Enrollment materials that will be distributed this year.

The foregoing shall not reduce the scope of any current agreement and will supersede provisions that are directly addressed in this Agreement.

If you are in accord with the foregoing and agrees thereto, please so indicate in the space provided and return one executed copy of this letter to the Company.

Very truly yours,

PACIFIC GAS & ELECTRIC COMPANY

By: _____
Chief Negotiator

The Union is in accord with the foregoing and agrees thereto as of the date hereof.

June 23, 1998

By: _____
Business Manager

Attachment A

APPEALS PROCEDURE
EXHIBITS C AND Q OF MEDICAL, DENTAL, AND VISION BENEFIT AGREEMENT

I. Appeals Procedure

A. Step One

Members are to call United HealthCare's Customer Services Representatives if they have concerns about their plan or coverage. If the Customer Services Representative is not able to resolve the member's concern, the member will be referred to a United HealthCare Quality Assurance Coordinator to initiate the appeals process. The member is encouraged to write his/her concerns in detail but a letter is not a requirement to initiate the appeals process. United HealthCare is required to acknowledge receipt of an appeal to the member within five working days. The United HealthCare Quality Assurance Coordinator and a physician/registered nurse will investigate the patient's problem and attempt to resolve it informally. If the problem is not resolved at this point, it will be heard by the First Level Grievance Committee which consists of physicians, nurses, Customer Services Representatives and administrative personnel. If the member is not satisfied with the Committee's determination, the member may appeal the issue to United HealthCare's Second Level Grievance Committee.

At both the first and second levels, every attempt will be made to resolve a formal appeal within fifteen working days of the request. If the review is delayed for any reason, the member will be informed in writing. The member will be offered a resolution in writing within seven days following the appeals meeting. If an appeal is not resolved within six months from the date the initial written appeal is received, the member will have the option of immediately submitting a written request to refer the issue to Step Two of the appeals procedure.

B. Step Two

The final level of appeal for members whose concerns are not satisfied with the determinations made at the First and Second Level Grievance Committees is arbitration. The arbitrator will be jointly selected by the member and the vendor through the American Arbitration Association. The costs of the arbitrator and any hearings, exclusive of the parties' presentations, will be shared equally by the member and the vendor.

II. Denial of Medical Necessity

United HealthCare may make denials for lack of medical necessity only after review by a physician. Both the provider and the member have the right to appeal.

III. Denial of Referral

If authorization for a procedure or a referral is denied, the Primary Care Physician should explain the denial and suggest alternative care, if appropriate. Both provider and member may appeal, informally through United HealthCare's Medical Director and formally through the appeals process.

IV. Denial Over UCR (Usual and Prevailing)

In network benefits for either the Point-Of-Service plan (Exhibit Q) or the PPO plan (Exhibit C) are based on fee schedule arrangements and member is not responsible for any charges above the scheduled amount or usual and prevailing charge (U&P).

If the member goes outside the network, all service are subject to U&P determination. The claim system screens each procedure by service code and geographical area by zip code of the provider then compares the charge to the 80th percentile. The portion of a provider's fee exceeding the usual and prevailing maxin um is reviewed by the claims examiner. Based on set guidelines for fee reduction vs. total charge, the examiner will deny the portion above U&P with a message explaining the circumstances to the provider and member.

Appeals to U&P reductions are referred to a claim team leader. He/she will review additional supporting documentation, i.e., operative reports, pathology reports, or a letter from a physician. If it appears additional payments are warranted, the claim will be reprocessed and a letter sent to the member explaining the additional allowance. If the claim team leader cannot determine if additional payments are warranted based on the information on hand, the claim is referred to the Medical Claim Review Nurse, or Medical Director, if needed. After the review by a Medical Review Claim Nurse and/or Medical Director, either additional payments will be allowed, or a letter explaining why no additional benefits are available will be sent to the provider and member.

Both the member and the provider may appeal the decision through the appeals process.

V. Application of 100% Payment Under Out-of-Network Conditions

Under certain conditions as provided in Exhibits C and Q, members may be eligible for payment at 100% of U&P when services are rendered out-of-network. Initially, members may request for full payment in the following manner:

1. The member may submit in writing or in a phone call to membership services who will document on the United HealthCare On-line Routing System.

2. The provider relations department or the medical management department will respond to the request within five working days.

3. If the member is not satisfied with the response in two above, the member may file a formal written appeal, or ask that the appeal be considered through the formal appeals process.

   This section may be used for, but not limited to, charges when members reside 30 miles from participating PPO providers, out-of-area travel, dependents living outside of the service area, and referrals from a participating provider to a non-participating provider. In the case of a request for full payment from a non-participating provider, the member must show evidence of a written referral from the participating provider.

AETNA HEALTH PLAN

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge for semi-private room; includes intensive and coronary care	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge; 60-day limit per calendar year for non-acute care	40 additional days allowed	+	
Outpatient Hospital and Emergency Room Care	$50 charge for emergency room (waived if admitted as impatient)	$50 for emergencies, in or out of Bay Area. No charge for outpatient services	No difference		
Maternity Care	$5 for first visit only	$5 for first visit only	No difference		
Well-Baby Care	No charge	No charge	No difference		
Doctor's Visits	$5 copay home or office, including second opinion	$5 copay home or office	No difference		
Routine Physical Examinations	$5 copay for screening and counseling as needed based on age, sex, and risk factors of patient; Age 2-17 - no charge	Age 18 and over - $5 gynecology (includes Pap smears); hearing correction exam-no charge; Age 2-17-no charge	No difference		
Immunizations and Injections	No charge	Included in office visit	No difference		
Eye Examinations	Under age 18 - no charge per refraction; no glasses or contacts	Under age 18 - no charge per refraction; no glasses or contacts	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	$5 per visit if pre-approved by Medical Director; home hospice care - $5 per visit	Elimination of $5 copay	+	
Inpatient Hospice Care	No charge	No charge for 30 days lifetime	Elimination of 30 day maximum	+	
Outpatient Physical Therapy	$5 copay per visit for 60 consecutive calendar days following first therapy	$5/visit up to 60 days per disability	No difference		
Outpatient Prescription Drugs	$10 copay for 30-34 day supply (retail) $10 copay for 90-100 day supply (mail) $10 copay for 28 day supply (oral contraceptive) $10 copay per device for contraceptive devices	$10 copay for 30-day supply (retail) $20 copay for 90-day supply (mail) 15% copay for up to 90-day supply with MMRX (Carveout)	No difference $10 less for mail Carveout (MMRX)	+	
Mental Health					
• Inpatient Care	No charge for up to 30 days per year	No charge for up to 30 days per calendar year	No difference		
• Outpatient Care	$20 copay for up to 20 days per year	$20/visit for 20 visits per calendar year	No difference		
Alcohol and Drug Care					
• Inpatient	No charge for detoxification; no day or frequency limits	No charge for detoxification or rehabilitation up to 30 days per calendar year	Elimination of 30 day maximum	+	
• Outpatient	$15 copay for unlimited days	$5/visit (60 days per calendar year)	Additional $10 copay per visit. Elimination of frequency limits	+	-
	Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	Carveout - (VBH)		
Chiropractic Care	Not covered	Not covered	No difference		

HEALTH NET

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge; includes intensive and coronary care	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge; 100-day limit	No difference		
Outpatient Hospital and Emergency Room Care	$25 charge for emergency room (waived if admitted as impatient)	$25 visit for emergencies (waived if admitted); must notify Health Net within 48 hours	No difference		
Maternity Care	No charge for hospital impatient delivery; $5/office visit	No charge for hospital and inpatient delivery; $5/office visit	No difference		
Well-Baby Care	$5 copay per visit	$5 visit	No difference		
Doctor's Visits	$5 copay office, including second opinion $10 copay home, including second opinion	Office visit $5 Home visit $10	No difference		
Routine Physical Examinations	$5 copay for screening and counseling as needed based on age, sex, and risk factors of patient	$5; pap smears included	No difference		
Immunizations and Injections	No charge	No charge	No difference		
Eye Examinations	$5 copay	$5	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	No charge	No difference		
Inpatient Hospice Care	No charge	Covered when authorized	No difference		
Outpatient Physical Therapy	$5 copay per visit for 60 consecutive calendar days following first therapy	No charge for short-term therapy; 60-day limit per episode	Addition of $5 copay for short-term therapy		-
Outpatient Prescription Drugs	$10 copay for 30-34 day supply (retail) $10 copay for 90-100 day supply (mail) $10 copay for 28 day supply (oral contraceptive) $10 copay per device for contraceptive devices	$10 copay for either one-month supply through participating pharmacy or 90-day supply through mail. 15% copayment for up to 90-day supply with MMRX (Carveout)	No difference No difference Carveout (MMRX)		
Mental Health • Inpatient Care • Outpatient Care	No charge for up to 30 days per year $20 copay for up to 20 days per year	No charge up to 45 days per calendar year for crisis intervention $20/visit; 20 visits per calendar year	15 days less coverage per year; Benefits no longer limited to only crisis intervention No difference	+	-
Alcohol and Drug Care • Inpatient • Outpatient Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	No charge for detoxification, no day or frequency limits $20 copay for up to 20 days per year Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	No inpatient benefits Outpatient care only for Detoxification and rehabilitation services. Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	Addition of inpatient benefits Addition of $20 copay Outpatient benefits expanded to $20/20 visits Carveout (VBH)	+ +	 -
Chiropractic Care	Not covered	Not covered	No difference		

HEALTH PLAN OF THE REDWOODS

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge; includes intensive care and coronary care	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge; limit of 60 days per calendar year	40 additional days allowed	+	
Outpatient Hospital and Emergency Room Care	$50 charge for emergency room (waived if admitted as impatient)	$50/visit (waived if admitted)	No difference		
Maternity Care	No charge	No charge	No difference		
Well-Baby Care	$5 copay per visit	$5 per visit	No difference		
Doctor's Visits	$5 copay office, including second opinion $15 copay home, including second opinion	Office visit - $5 Home visit - $20	No difference $5 decrease in copay	+	
Routine Physical Examinations	$5 copay for screening and counseling as needed based on age, sex, and risk factors of patient	$5 per visit	No difference		
• Immunizations	No charge	No charge	No difference		
• Injections	$5	$4	$1 increase in copay		-
Eye Examinations	$5	$5 visit	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	$10/visit for home health care; home hospice care -covered with prior authorization	Elimination of copay	+	
Inpatient Hospice Care	No charge	Prior authorization required	No difference		
Outpatient Physical Therapy	$10 copay per visit for 60 consecutive calendar days following first therapy	$10/visit	No difference		
Outpatient Prescription Drugs	$5 copay for 30-34 day supply (retail) $5 copay for 90-100 day supply (mail) $5 copay for 28 day supply (oral contraceptive) $5 copay per device for contraceptive devices	$5 copay for 1-month supply (retail) 15% copay for up to 90-day supply with MMRX	No difference Addition of mail order drugs through HMO Carveout (MMRX)	+	
Mental Health					
• Inpatient Care	No charge for up to 30 days per year	30 days/calendar year; 90 days-lifetime	No difference		
• Outpatient Care	$30/individual visit; $15/visit for group therapy up to 20 combined visits per calendar year	$30/individual visit; $15/visit for group therapy up to 20 combined visits per calendar year	No difference		
Alcohol and Drug Care • Inpatient • Outpatient	Covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	Covered by separate Mental Health, Alcohol and Drug Care Program with referral by VBH	No difference - Carveout (VBH)		
Chiropractic Care	Not covered	Not covered	No difference		

KAISER NORTH

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge; includes intensive care and coronary care	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge for up to 100 days per benefit period	No difference		
Outpatient Hospital and Emergency Room Care	No charge	No charge	No difference		
Maternity Care	No charge for prenatal visits and hospital impatient delivery	No charge	No difference		
Well-Baby Care	No charge	No charge	No difference		
Doctor's Visits	office visit - no charge home visit - $5	office visit - no charge home visit - $5	No difference		
Routine Physical Examinations	No charge	No charge - as necessary; Pap smears included	No difference		
Immunizations and Injections	No charge	No charge	No difference		
Eye Examinations	No charge	No charge	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	No charge to members in service area when prescribed	No difference		
Inpatient Hospice Care	No charge	Covered when selected as an alternate to traditional services	No difference		
Outpatient Physical Therapy	No charge for short-term treatment	No charge for short-term treatment	No difference		
Outpatient Prescription Drugs	$10 copay for 30-34 day supply (retail) $10 copay for 90-100 day supply (mail) $10 copay for 28 day supply (oral contraceptive) $10 copay per device for contraceptive devices	$10 copay for up to 100-day supply (retail) 15% copay for up to 90-day supply with MMRX - (Carveout)	Retail benefit is only for 30-34 day supply not 100-day. Addition of mail order drugs through HMO Carveout (MMRX)	+	-
Mental Health • Inpatient Care • Outpatient Care	No charge for up to 45 days per calendar year Psychiatric care - no charge for up to 20 visits per calendar year when prescribed by a plan physician	No charge for up to 45 days per calendar year Psychiatric care - no charge for up to 20 visits per calendar year when prescribed by a plan physician	No difference No difference		
Alcohol and Drug Care • Inpatient • Outpatient	No charge for detoxification, if required for medical reasons No charge	No charge for detoxification, if required for medical reasons No charge	No difference No difference		
Chiropractic Care	Not covered	Not covered	No difference		

KAISER SOUTH

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge; includes intensive care and coronary care	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge for up to 100 days per benefit period when prescribed by a plan physician	No difference		
Outpatient Hospital and Emergency Room Care	No charge	No charge	No difference		
Maternity Care	No charge for prenatal visits and hospital impatient delivery	No charge	No difference		
Well-Baby Care	No charge	No charge	No difference		
Doctor's Visits	office visit - no charge home visit - no charge	office visit - no charge home visit - no charge	No difference		
Routine Physical Examinations	No charge	No charge; Pap smears and mammograms included	No difference		
Immunizations and Injections	No charge	No charge	No difference		
Eye Examinations	No charge	No charge; no glasses or contacts	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	No charge for part-time, intermittent skilled nursing visits when prescribed	No difference		
Inpatient Hospice Care	No charge	Covered when selected as an alternate to traditional services	No difference		
Outpatient Physical Therapy	No charge for short-term treatment	No charge for short-term treatment	No difference		
Outpatient Prescription Drugs	$5 copay for 30-34 day supply (retail) $5 copay for 90-100 day supply (mail) $5 copay for 28 day supply (oral contraceptive) $5 copay per device for contraceptive devices	$5 copay for up to 100-day supply (retail) 15% copay for up to 90-day supply with MMRX - (Carveout)	Retail benefit reduced to 30-34 day supply versus 100-day supply; Addition of mail order drugs through HMO Carveout for mail (MMRX)	+	-
Mental Health • Inpatient Care • Outpatient Care	No charge for up to 45 days per calendar year Psychiatric care - no charge for up to 20 visits per calendar year	No charge for up to 45 days per calendar year Psychiatric care - no charge for up to 20 visits per calendar year	No difference No difference		
Alcohol and Drug Care • Inpatient • Outpatient	No charge for detoxification, if required for medical reasons; Unlimited outpatient rehabilitation - no charge	No charge for detoxification, if required for medical reasons Unlimited outpatient rehabilitation - no charge	No difference No difference		
Chiropractic Care	Not covered	Not covered	No difference		

LIFEGUARD

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge for semi-private room; includes intensive care	No difference		
Skilled Nursing Facility	No charge for 100 days	$5/day for up to 60 days/year; plan authorization required	40 additional days allowed	+	
Outpatient Hospital and Emergency Room Care	$25 charge for emergency room (waived if admitted as impatient)	$25/visit at hospital emergency room (waived if admitted); $15/visit at contracted Urgent Care Center	No difference		
Maternity Care	$5/office visit; no charge for hospital impatient delivery	$5/office visit; no charge for hospital and inpatient delivery	No difference		
Well-Baby Care	$5 copay per visit	$5 visit	No difference		
Doctor's Visits	$5 copay home or office, including second opinion	Office visit - $5 Home visit - $5	No difference		
Routine Physical Examinations	$5 copay for screening and counseling as needed based on age, sex, and risk factors of patient	$5/visit; gynecological exam - $5/visit (includes Pap smears)	No difference		
Immunizations and Injections	No charge	Included in office visit	No difference		
Eye Examinations	No charge	Refraction - not covered	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	Home health care - $5/day; Hospice care - no charge	Elimination of $5 copay	+	
Inpatient Hospice Care	No charge	Covered for specific services when authorized	No difference		
Outpatient Physical Therapy	$15 copay per visit for 60 consecutive calendar days following first therapy	$25/visit; prior authorization required	$10 decrease in copay	+	
Outpatient Prescription Drugs	$10 copay for 30-34 day supply (retail) $10 copay for 90-100 day supply (mail) $10 copay for 28 day supply (oral contraceptive) $10 copay per device for contraceptive devices	$10 copay for either 30-day supply through participating pharmacy (retail) or 90-supply through mail; or 15%copayment for up to 90-day supply with MMRX	No difference No difference Carveout (MMRX)		
Mental Health • Inpatient Care • Outpatient Care	No charge for up to 30 days per year $20 copay for up to 20 days per year	No charge up to 30 days per calendar year for crisis intervention $20/visit; 20 outpatient visits for crisis intervention and evaluation	No difference No difference		
Alcohol and Drug Care • Inpatient • Outpatient	No charge for detoxification; no day or frequency limits $20 copay for up to 20 days per year Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VHB.	Inpatient detoxification only - no charge. No outpatient benefits Also covered by separate Mental Health, Alcohol and Drug Care Program with referral by VHB.	No difference Addition of outpatient benefits Carveout - (VBH)	+	
Chiropractic Care	Available as rider	$5/visit at contracting chiropractor, up to 20 visits per calendar year	With rider, no difference		

PACIFICARE

(Used 1997 PBGH Model)

PROVISIONS	PBGH COMPARATIVE PLAN	PG&E PLAN	DIFFERENCE	+	-
Hospital Stay	No charge; Room/supplies, surgery services, professional services	No charge for semi-private room	No difference		
Skilled Nursing Facility	No charge for 100 days	No charge; 100 days per calendar year from first treatment, per disability	No difference		
Outpatient Hospital and Emergency Room Care	$25 charge for emergency room (waived if admitted as impatient)	$25 copayment per visit (waived if admitted as an inpatient)	No difference		
Maternity Care	No charge for prenatal visits and hospital impatient delivery	No charge	No difference		
Well-Baby Care	No charge to age 2	No charge to age 2	No difference		
Doctor's Visits	$5 copay home or office, including second opinion	$5 per home or office visit	No difference		
Routine Physical Examinations	$5 copay, age 2 and older, for screening and counseling as needed based on age, sex, and risk factors of patient	$5/visit age 2 and older	No difference		
Immunizations and Injections	$5 copay age 2 and older	$5/visit age 2 and older	No difference		
Eye Examinations	$5 copay	$5 copayment for vision screening/ refractions; lenses and frames not covered	No difference		
X-Rays and Lab Tests	No charge	No charge	No difference		
Pre-Admission Testing	No charge	No charge	No difference		
Home Health Care & Home Hospice Care	No charge	Home health care - $5/day; home hospice care - $5 up to 120 days per lifetime	Elimination of $5/day copay	+	
Inpatient Hospice Care	No charge	$5/visit up to 120 days per lifetime	Elimination of 5/visit copay	+	
Outpatient Physical Therapy	$5 copay per visit for 60 consecutive calendar days following first therapy	$5 copayment up to 60 consecutive calendar days from first treatment per condition	No difference		
Outpatient Prescription Drugs	$10 copay for 30-34 day supply (retail) $10 copay for 90-100 day supply (mail) $10 copay for 28 day supply (oral contraceptive) $10 copay per device for contraceptive devices	$10 copayment for either 1-month supply through participating pharmacy or 90-day supply through PacifiCare mail-order plan (unlimited maximum) or 15% copayment for up to 90-day supply with MMRX	No difference No difference Carveout (MMRX)		
Mental Health					
• Inpatient Care	No charge for up to 30 days per year	No charge for up to 30 days per year	No difference		
• Outpatient Care	$20 copay for up to 20 days per year	$20/visit for up to 20 visits per year	No difference		
Alcohol and Drug Care					
• Inpatient	No charge for detoxification; no day or frequency limits	Detoxification only - no charge.	No difference		
• Outpatient	$20 copay for up to 20 days per year Also covered by separate mental Health, Alcohol and Drug Care Program with referral by VBH	$20/visit for up to 20 days per year Also covered by separate mental Health, Alcohol and Drug Care Program with referral by VBH	No difference Carveout - (VBH)		
Chiropractic Care	Not covered	Not covered	No difference		