2021 Benefits for Hiring Hall Employees

What you need to do

Within 31 days of your start date, read this guide and decide if you want to elect the Anthem Gold Plan.

Your Personalized Enrollment Worksheet, which details the benefits and associated costs for which you are eligible for, will be mailed to your home address. If you don't receive it within 14 days of your hire date**,** please call the PG&E Benefits Service Center at **1-866-271-8144**.

IBEW and ESC employees: Make your election early to avoid a costly surprise.

Make your election as soon as you decide whether to enroll in or waive coverage.

If you wait until the end of the enrollment period to elect the Anthem Gold Plan, you may have to repay money you shouldn't have received from your Benefit Equivalent Allowance (BEA). **Enrolling in the Anthem Gold Plan will make a difference in your take-home pay.** The BEA will be reduced to help cover the cost of your premiums. See page 5 for details.

Language Assistance

NONDISCRIMINATION AND ACCESSIBILITY

For people whose primary language is not English, PG&E's health plans provide free language services, such as qualified interpreters and information written in other languages. If you need these services, contact the PG&E Benefits Service Center by phone:

1-866-271-8144 (TTY: 1-800-424-0253)

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingü.stica. Llame al **1-866-271-8144 (TTY: 1-800-424-0253)**.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1**-866-271-8144 (TTY: 1-800-424-0253)**。
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-271-8144 (TTY: 1-800-424-0253)**.
Navajo (Dine)	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih **1-866-271-8144 (TTY: 1-800-424-0253)**.

Health coverage required by California

California state law requires that most California residents have qualifying health insurance. Make sure you're enrolled in a medical plan that meets these requirements. Otherwise, you could be subject to a state tax penalty (see ftb.ca.gov). The PG&E-sponsored plans and Medicare meet the state requirements.

Where to find legal information about your benefits

These legal documents provide more details about your benefits:

Annual Summary of Benefits and Coverage (SBC) The annual SBC is an easy-to-understand summary of a health plan, showing how you and the plan would share the cost for covered services. SBCs allow you to make apples-to-apples comparisons of different health plans, which can make it easier to choose a plan.	**Electronic version:** Go to **mypgebenefits.com > Resources > Legal Notices.**
Annual Legal Information Booklet The annual Legal Information booklet provides important information about your rights under PG&E's health plan. This booklet includes legal notices that are required to be distributed annually.	**Paper version:** Call the PG&E Benefits Service Center at **1-866-271-8144** to request a paper copy.
Summary Plan Description (SPD) The Summary of Benefits Handbook (PG&E's SPD) is an important document that explains: • The provisions of your health benefit plans • How the plans work • Eligibility rules for coverage • How benefits are calculated and paid • How to file a claim and appeal claim denials	**Electronic version:** Go to **spd.mypgebenefits.com.**
	Paper version: Call the PG&E Benefits Service Center at **1-866-271-8144** to request a paper copy.

This Benefits for Hiring Hall Employees guide is a summary of your benefits. It does not include the important legal definitions or limits that are in plan documents or contracts governing your benefits, and it does not replace those legal documents. In case of conflict, those legal documents govern your benefits. Since future conditions affecting the company cannot be foreseen, the company reserves the right to amend or terminate the plans at any time, subject to notice provisions required under applicable collective bargaining agreements.

You can find additional plan details in the Summary of Benefits Handbook, available at **spd.mypgebenefits.com** or by calling the PG&E Benefits Service Center.

What you need to know

You have two options when you are hired into a Hiring Hall position:

1. Enroll in the Anthem Gold Plan and receive a reduced hourly Hiring Hall benefit allowance; or
2. Waive coverage in the Anthem Gold Plan and receive a full, unreduced hourly Hiring Hall benefits allowance.

If you enroll in the Anthem Gold Plan: When coverage will start

Your Anthem Gold Plan coverage start date depends on whether you're joining the Hiring Hall as a PG&E retiree—or with no prior service at PG&E.

Your coverage will start:	Enrolling as a PG&E retiree or surviving dependent, or with prior PG&E service?	Enrolling with no prior PG&E service?
	The first of the month following your hire date	Your date of hire

Are you enrolling as a newly hired Hiring Hall employee?

If you're enrolling as a newly hired Hiring Hall employee outside Open Enrollment, you have 31 days from the date you were hired to make your election.

NOTE: If you enroll near the end of the 31-day deadline, your first benefit premium deduction could be for two months—the cost of the first month's premium plus the cost of the second month's premium. You'll be responsible for paying the total premium cost for both months. After that, your benefit premium deductions will be for one month at a time. See page 5 for 2021 monthly premiums.

Are you a surviving spouse or surviving dependent?

Your PG&E-sponsored retiree medical coverage will end on the last day of the month in which you become a Hiring Hall employee—even if you don't elect the Anthem Gold Plan. That's because you can't be enrolled in the PG&E-sponsored retiree medical plan while you're an employee.

As a surviving spouse or surviving dependent, you will NOT be allowed to re-enroll in the PG&E-sponsored retiree medical plan after your Hiring Hall assignment ends.

See **What happens when your Hiring Hall assignment ends?** on page 21 for details.

If you later become a regular employee and you elect employee coverage

Your employee coverage will start the first of the month following your regular employee hire date. See Going back to work as a regular employee? on page 21 for details.

IMPORTANT: You need to actively re-enroll for PG&E-sponsored retiree medical coverage when your Hiring Hall coverage ends. **Re-enrollment is not automatic**. See page 21 for details.

Enrolling in the Anthem Gold Plan will affect your pay

You automatically get a Benefit Equivalent Allowance (BEA) of:

IBEW employee: 25%	OR	ESC employee: $8.22

Enrolling in the Anthem Gold Plan will make a difference in your take-home pay.
If you elect the Anthem Gold Plan, your BEA will be reduced by **$4.02 per hour** for each straight-time hour worked. Overtime hours worked won't get a reduction.

Make your election early to avoid having to repay your BEA.

If you wait until the end of the enrollment period to elect the Anthem Gold Plan, you may have to repay money you shouldn't have received from your BEA. That's because the BEA will be reduced to help cover the cost of your premiums. If you waive coverage, you'll get the full BEA.

This reduction to your BEA is <u>in addition to</u> your monthly premium costs for the Anthem Gold Plan:

Anthem Gold Plan Monthly Cost of Coverage*	You Pay Monthly	PG&E Pays Monthly	Total Monthly Cost
Employee only	$101.79	$697.13	$798.92
Employee + spouse/registered domestic partner	$1,036.85	$640.91	$1,677.76
Employee + children	$781.82	$656.24	$1,438.06
Employee + spouse/registered domestic partner + children	$1,716.88	$600.03	$2,316.91

Your total cost for Anthem Gold Plan coverage

Your total cost for Anthem Gold Plan coverage includes:

- Your share of the monthly premium cost, described in the table on the previous page—taken from the second paycheck each month

PLUS

- The $4.02-per-hour reduction to your Benefit Equivalent Allowance on all straight-time hours worked— taken from every paycheck

Wondering how the medical deduction is calculated?

Call the PG&E Payroll Service Center at **415-973-3767**.

A payroll representative can view your paycheck and discuss your specific situation.

If you don’t enroll in the Anthem Gold Plan

If you don’t elect the Anthem Gold Plan, you’ll have no PG&E-sponsored medical coverage.

You’ll continue to receive the BEA paid to you in addition to your Hiring Hall wages.

If you later become a regular employee and you elect employee coverage

Your employee coverage will start the first of the month following your regular employee hire date—even if you waived Anthem Gold Plan coverage. This means you could have a period of time without coverage after you become a regular employee.

See **Going back to work as a regular employee?** on page 21 for details.

Other benefits

As a Hiring Hall employee, you're eligible for the Voluntary Plan, Other Time Off Benefits, Commuter Transit Program and the PG&E Health Center.

If you were a PG&E retiree before becoming a Hiring Hall employee, you keep any Postretirement Life Insurance you had as a PG&E retiree.

Voluntary Plan: Opt in or out anytime

Eligible California Utility employees are automatically covered under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (the "Voluntary Plan").

This income protection plan pays a benefit if you're unable to work due to a non-work related injury or health condition, including pregnancy, and you're experiencing a wage loss. If you're an eligible California Utility employee, you can opt in or out of the Voluntary Plan anytime during the year through your myPlans Connect account, with changes effective according to a special schedule.

The cost of contributions for the Voluntary Plan is the same as for California's State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan"). Actual amounts will show on your pay statement. You're required by law to contribute to one or the other. If you opt out of the Voluntary Plan, you'll be covered by the State Plan.

Visit mypgebenefits.com > Time Off and Accommodations > Voluntary Plan for details and to see a comparison of State and Voluntary Plan benefits. The comparison will help you understand the better benefits offered through the Voluntary Plan.

Time Off Information

Everyone needs time off to recharge. PG&E provides a variety of time off options for diverse needs.

Sick Pay
Hiring Hall employees are eligible for 24 hours of sick time per year, available for use after 90 days of employment. The 90 days (cumulative) in a 12-month period requirement is counted in calendar days, based on your employment dates.

After the initial award at 90 days, hours are awarded annually on your first day of attendance in the New Year if you are otherwise eligible. Any unused hours will not roll-over to the New Year.

Sick pay can be used for you or a family member for preventive care or care of an existing health condition or for specified purposes if you are a victim of domestic violence, sexual assault or stalking. For more information and additional answers to frequently asked questions, please visit mypgebenefits.com > Time Off and Accommodations.

Paid Sick Leave under state law provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and

c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for: 1) requesting or using accrued sick days; 2) attempting to exercise the right to use accrued paid sick days; 3) filing a complaint or alleging a violation under the law; or 4) cooperating in an investigation or prosecution of an alleged violation or opposing any policy or practice or act that is prohibited under the law.

Leaves of Absence
You may be eligible for family and medical leave under the Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) if you have completed 12 or more months of service with the company (need not be consecutive), worked at least 1250 hours within 12 months immediately preceding the leave start date, have not already exhausted your 12-week FMLA/CFRA entitlement and have a qualifying reason to take leave. Pursuant to California's Fair Employment and Housing Act (FEHA), you are entitled to up to four months of medical leave, if medically necessary, for a disability on account of pregnancy, prenatal care, childbirth, or related medical conditions. There is no service requirement to be eligible for PDL (must work in California).

For more information, including other leave benefits you may be eligible for, who to call to report a leave and your responsibilities as an employee during the leave process, please visit **mypgebenefits.com > Time Off and Accommodations > Leave of Absence**.

If you have questions on sick pay or leaves of absence policies, email PGELeaveTeam@pge.com.

Commuter Transit Program: Enroll or change anytime

The Commuter Transit Program helps make your commute a little easier by letting you pay for transit products and services and commute-related parking expenses with before-tax contributions deducted from your pay.

As a Hiring Hall employee, you can enroll anytime through HealthEquity l WageWorks—but the cutoff is the first of the month for benefits to be ready the following month. Log in to your myPlans Connect account and click the HealthEquity l WageWorks link. Visit **mypgebenefits.com** for details about the Commuter Transit Program.

Estimate carefully

No refunds will be given for excess Commuter Transit contributions after your Hiring Hall assignment ends.

PG&E Health Center: Holistic health services at the San Francisco General Office

The PG&E Health Center was specially designed for PG&E employees. Everything from the layout, staff, services and third-party vendor—Premise Health—is designed to provide high-quality, convenient, affordable care, with the focus on primary and preventive care.

The clinic's medical team takes a holistic approach—learning about your medical history and lifestyle to provide care and treatment options that make sense for you—making you a partner in your own health.

The medical team includes an onsite physician, nurse practitioner, physical therapist, chiropractor, acupuncturist and health risk condition management nurse/wellness coach, along with registered nurses and certified medical assistants.

Key services include:

- Coordinated and customized primary and preventive care services
- Same-day acute and urgent care services
- Chiropractic and acupuncture treatments
- Secure electronic medical records
- Clinical lab services
- Health education and coaching
- Condition management
- Physical therapy
- Occupational health/work injury care

If you're enrolled in the Anthem Gold Plan: The clinic will bill Anthem just like other clinics do. If there's an outstanding balance, you'll be responsible for promptly paying it.

For details about the PG&E Health Center—including costs—go to: **mypgebenefits.com > Physical Health > PG&E Health Center.**

Location:	77 Beale Street, 3rd floor San Francisco, CA 94105
Phone:	**628-201-3555**
Clinic hours:	Monday–Friday, 7 a.m.–4 p.m.
Lab hours:	Monday–Friday, 7 a.m.–3:30 p.m.

Enrolling in the Anthem Gold Plan

You can enroll in the Anthem Gold Plan online or by phone within 31 days of your hire date. If you choose not to enroll, the next time you'll be able to enroll will be during the next Open Enrollment season in November, or if you have a life event – such as getting married or having a baby.

ONLINE

Available 24/7

Log in to your myPlans Connect account:

From *PG&E@Work for Me*:

Click **About Me > My Benefits > myPlans Connect** and you'll be automatically logged in to your MyPlans Connect account.

From your computer or mobile device:

Go to **mypgebenefits.com**

OR

BY PHONE

Available Monday–Friday 7:30 a.m.–5 p.m. Pacific time

Call the PG&E Benefits Service Center: **1-866-271-8144**

Representatives can:

- Help you enroll online or by phone
- Answer questions about the Anthem Gold Plan

Change your mind? Make a mistake?

That's not a problem. With myPlans Connect, you can enroll or change your elections as often as you like as long as you're within your 31-day window. If you need to make changes after that, you have up to 10 business days after your enrollment window to call the PG&E Benefits Service Center to correct any enrollment errors.

Setting up your myPlans Connect account

Registering is easy:

1. From any computer or mobile device, go to **mypgebenefits.com** and click **Log In** under **Manage Your Benefits**
2. Click on **Take Me to the myPlans Connect Login Page**
3. Click **Get Started** under **New Users**
4. Follow the prompts to register your account and set up your user ID and password
5. Confirm your email address and add a mobile phone number as a contact method
6. Choose your desired contact method to receive a temporary numeric code to confirm your identity each time you log in

That's all it takes to get year-round access to your personalized benefits account. You'll be able to:

- See what benefits you have
- Update your dependents
- Find tools, resources and details about your benefits

Best of all, myPlans Connect is always open—you can access it from your computer or mobile device 24 hours a day, 7 days a week.

Enrolling dependents in the Anthem Gold Plan

As a Hiring Hall employee, you have an opportunity to enroll your eligible dependents in the Anthem Gold Plan.

You'll need to provide your dependent's name, birth date and Social Security number when you enroll. Generally, you can enroll dependents online or by phone.

You need to call the PG&E Benefits Service Center if:

- You or any dependent is newly eligible for Medicare; or
- You want to add or drop a Medicare-eligible dependent

You can't do this online.

Please check your Personalized Enrollment Worksheet to confirm the dependents you want to cover are listed as covered ("Y"). You'll see a Y, N or P by each dependent's name:

Y = Covered	N = Not Covered	P = Pending Verification

If the dependent you want to cover is:

N = Not	P = Pending Verification	Not listed on your worksheet

You'll need to provide verification documents to the PG&E Benefits Service Center.

Warning! Verification of dependent eligibility will be required

You will need to provide verification documents to the PG&E Benefits Service Center to confirm any new dependent's eligibility for health benefits.

If you cover an ineligible dependent, you'll be required to make restitution to the Participating Employer* for health care coverage—up to two full years of the cost of coverage. **Knowingly covering an ineligible dependent is considered fraud, and can be grounds for termination of employment.** For details, visit **spd.mypgebenefits.com**.

To drop ineligible dependents, call the PG&E Benefits Service Center or log in to myPlans Connect.

*Participating Employers are listed on page 29.

Providing dependent verification

If you're enrolling online, the orange message box on the homepage will tell you that a dependent needs to be verified. Once you click the *Your Dependent(s) Information Requires Review* box, you'll be able to see:

- Which dependent needs verification
- What documents you need to submit

You can upload, mail or fax the required documents.

If you're enrolling by phone, the PG&E Benefits Service Center representative will help you with the verification process. You'll still need to submit appropriate verification documentation.

Want to enroll your children?

You can enroll your children up to age 26 for medical coverage. They can be employed or married—and they don't have to be students.

Is your dependent child disabled?

If your child is disabled, under age 26 and currently enrolled in a PG&E-sponsored medical plan, you'll need to get your child medically certified as disabled **before he or she reaches age 26** to continue coverage from age 26 onward. You'll need to get the certification directly from your medical plan.

You can cover disabled dependents age 26 or older **only if** they meet both of these conditions:

They were already enrolled in a PG&E-sponsored plan when they turned 26	**AND**	They were medically certified as disabled by a PG&E-sponsored medical plan before they turned 26

You may not cover disabled dependents age 26 or older if they fail to meet either one of these conditions.

Not sure if your dependent is eligible?

Call the PG&E Benefits Service Center at **1-866-271-8144**.

Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

Check your confirmation statement

Following your enrollment, a paper confirmation statement will be mailed to your home address, and will show what benefits you'll have during your Hiring Hall assignment.

Planning to move?

Make sure your primary home address and phone number are correct. PG&E needs your correct address to send you important communications about your benefits.

As a Hiring Hall employee, you can update your address and phone number:

- Online at ***PG&E@Work for Me***

OR

- Call the **HR Solutions Center: 415-973-4357**

Questions? Submit a ticket through **AskHR**.

Anthem Gold Plan ID cards

Enrolling in the Anthem Gold Plan? Adding a dependent?

You'll get your new ID card within 10-14 business days after your election takes effect. If you don't receive your ID card on time, call Anthem.

Don't want to wait? You can:

- Use your confirmation statement as proof of coverage if you need to see a doctor before your ID card arrives
- Print a copy of your ID card from Anthem's website
- View your ID card on your mobile device by downloading the Anthem Sydney app via Google Play or App Store
- Print a temporary ID card for prescription drug plan coverage at **express-scripts.com**

Changing coverage if your life changes

Getting married or divorced? Adopting a child? Big changes like these are **life events.** Chances are, you'll want to change your benefits coverage, too—like adding or dropping a dependent.

Already enrolled in the Anthem Gold Plan when you experience the life event? You have 31 days from the date of your life event to make allowable midyear changes to your coverage (180 days from the birth or adoption of a child).

Not enrolled in the Anthem Gold Plan when you experience the life event? Call the PG&E Benefits Service Center at **1-866-271-8144** for information about your options.

Questions about your benefits?

Call the PG&E Benefits Service Center: **1-866-271-8144**

Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific time.

Anthem Gold Plan

The Anthem Gold Plan helps build a better you by offering some free preventive and primary medical care so you can be sure you're getting the right care, right away.

The Anthem Gold Plan has a nationwide network of providers.* You can use any licensed provider you choose, but you'll pay less when you use in-network Anthem providers and Express Scripts-participating pharmacies. That's because they've agreed to accept Anthem and Express Scripts' negotiated rates.

*Only urgent/emergency care is covered outside the U.S.

Choose and register a primary care physician (PCP)

A primary care physician (PCP) can make a big difference to your health, saving you time and money by ensuring your overall care makes sense based on your history, specialists, medications and lab results. Your PCP can help you avoid costly duplication of tests, and check to make sure all of your medications work well together.

Contact Anthem to find out how you can elect an Enhanced Personal Health Care and Blue Distinction Total Care doctor. These doctors help you get the right level of care, from the right kind of doctor, at the right time. Call Member Services at the number on your Anthem ID card or go to **anthem.com/ca** and log in to get started. It only takes a few minutes.

Benefits overview

GENERAL	
Annual deductible	**Annual out-of-pocket maximum**
• $1,000 per person	• $2,400 per person
• No more than $2,000 per family	• No more than $4,800 per family

The annual out-of-pocket maximum includes amounts you pay toward the annual deductible. It does not include any penalty charges, amounts in excess of the reasonable and customary amounts for out-of-network charges, or charges for services that aren't covered.

No lifetime benefit maximum except for infertility

services No pre-existing condition exclusions

Remember:

Out-of-pocket maximum = deductible + coinsurance

"Do you speak benefits?"

You'll see some technical terms that explain how the medical plan works. For help understanding, see the Glossary on page 24.

MEDICAL	
Primary Care Includes routine physical exams	**Doctor visits** • No deductible • Four free visits a year per enrolled person; you're responsible for 10% of covered charges for additional visits **Note:** If one of the first four visits is a physical exam, it counts toward your four free visits.
Specialty Care	• Deductible required • You're responsible for 20% of covered charges
Preventive Services Example: Routine mammograms, pap smears, colonoscopies Go to **mypgebenefits.com > Life Events > I Accepted a Hiring Hall Position** for a list of free services	• No deductible • Free if included on the list of free services and coded as preventive **Note:** Diagnostic tests and ancillary services like anesthesia and facility fees are covered separately and aren't free (see page 15 for Lab Tests and X-Rays and for Outpatient Hospital).
Immunizations Go to **mypgebenefits.com > Life Events > I Accepted a Hiring Hall Position** for a list of free services	• No deductible • Free if included on the list of free services
Maternity Care	**Office visits** • No deductible • Free **Screenings and tests (e.g., sonograms)** • Deductible required • You're responsible for 20% of covered charges **Hospital-based delivery** • Deductible required • You're responsible for 20% of covered charges Authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for Cesarean section)
Well-Baby Care	• No deductible • Free to age two
Infertility Services	• Deductible required • You're responsible for 20% of covered charges • $7,000 lifetime benefit maximum; includes balances from prior plans
Urgent Care	Covered as **primary care**—no deductible; you're responsible for 10% of covered charges after the first four free primary care visits
Emergency Room	• Deductible required • You're responsible for 20% of covered charges
Ambulance Services	• Deductible required • You're responsible for 20% of covered charges

MEDICAL, continued	
Lab Tests and X-Rays Go to **mypgebenefits.com > Life Events > I Accepted a Hiring Hall Position** for a list of free services	**Routine preventive screenings that are on the list of free services** • No deductible • Free **All other procedures, including diagnostic tests and most lab tests** • Deductible required • You're responsible for 20% of covered charges COVID-19 testing may be covered at no charge during the declared period of the national public emergency. Preauthorization required for advanced imaging procedures. Before treatment, call Anthem to find out if a procedure needs preauthorization.
Chiropractic and Acupuncture	• Deductible required • You're responsible for 10% of covered charges for first five visits per year; 20% for additional visits Preauthorization required after five visits
Outpatient Physical Therapy, Speech Therapy, Occupational Therapy	• Deductible required • You're responsible for 10% of covered charges for first five visits per year; 20% for additional visits Preauthorization required after 24 visits
Outpatient Hospital	• Deductible required • You're responsible for 20% of covered charges
Hospital Stay	• Deductible required • You're responsible for 20% of covered charges Preauthorization required for non-emergency care, $300 penalty if not obtained; covers semi-private room (private if medically necessary)
Skilled Nursing Facility	• Deductible required • You're responsible for 20% of covered charges Preauthorization required, $300 penalty if not obtained; excludes custodial care
Home Health Care	• Deductible required • You're responsible for 20% of covered charges Preauthorization required, $300 penalty if not obtained; excludes custodial care
Hospice Care	• No deductible • Free Preauthorization required, $300 penalty if not obtained; excludes custodial care
Durable Medical Equipment	• Deductible required • You're responsible for 20% of covered charges Preauthorization required for purchase or cumulative rental over $1,000; $300 penalty if not obtained
Hearing Aids	• Deductible required • You're responsible for 20% of covered charges for evaluation, fittings, equipment • Limited to one medically necessary hearing aid per ear every three years

PRESCRIPTION DRUGS	
Retail Drugs	• Deductible required (combined with medical deductible) • You're responsible for 15% of covered charges for generic; 25% for brand (Generic Incentive Provision and Step Therapy Provision apply) • 30-day supply **Mandatory mail order for most maintenance drugs:** You can get the first three fills of the same prescription at a retail pharmacy; no coverage for additional fills except through the Express Scripts mail-order program.
Mail-Order Drugs Go to **mypgebenefits.com > Life Events > I Accepted a Hiring Hall Position** for a list of free medications	Select drugs are free, no deductible In order for the drug to be free, you must use the Express Scripts mail-order program **For drugs not on the list of free medications:** • Deductible required • You're responsible for 10% of covered charges for generic; 20% for brand (Generic Incentive Provision and Step Therapy Provision apply) • 90-day supply
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. 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.
Step Therapy Provision	For certain medications, the Anthem Gold Plan requires that members try generic medication or lower-cost brand-name alternatives first, instead of higher-cost brand-name drugs. Members who require higher-cost brand-name drugs for medically necessary reasons can appeal to Express Scripts by having their doctor submit the reason why the higher-cost brand-name drug is required. Express Scripts will review and approve exceptions if the higher-cost brand-name drugs are required.
Drugs for Infertility, Sexual Dysfunction and Memory Enhancement	• Deductible required • If medically necessary, standard retail and mail-order coverage applies • If not medically necessary, you're responsible for 50% of covered charges for retail and mail-order purchases

MENTAL HEALTH AND SUBSTANCE USE DISORDER All care provided and administered by Beacon Health Options	
Outpatient Mental Health	• No deductible • You pay 10% of covered charges
Inpatient Mental Health	• Deductible required • You pay 20% of covered charges Requires preauthorization by Beacon Health Options; $300 penalty if you fail to notify Beacon Health Options within 48 hours; no limit on number of stays
Outpatient Substance Use Disorder	• No deductible • You pay 10% of covered charges
Inpatient Substance Use Disorder	• Deductible required • You pay 20% of covered charges Requires preauthorization by Beacon Health Options; $300 penalty if you fail to notify Beacon Health Options within 48 hours; no limit on number of stays
Applied Behavioral Analysis (Autism Treatment)	• No deductible • Free • No limits Requires preauthorization by Beacon Health Options

What else you need to know

Do you have PG&E retiree medical coverage?

You're eligible for PG&E retiree medical coverage if you were age 55 or older when you retired from PG&E, and:

- You retired with at least 10 years of service—or
- You were a Management or Administrative & Technical (A&T) employee hired before 2004 (no minimum service requirement).

PG&E-sponsored retiree or active medical plan coverage will end for you and your enrolled dependents on the last day of the month in which you become a Hiring Hall employee. See additional details about what happens to your coverage when your Hiring Hall assignment ends on page 21.

You have options for yourself and your eligible dependents:

Enroll in the Anthem Gold Plan

The Anthem Gold Plan has a nationwide network of providers.

See page 13 for details.

OR

Work for another employer (Signatory Contractor)—and stay enrolled in your PG&E-sponsored retiree medical plan

PG&E's operating departments may have a choice of seeking a Hiring Hall employee or contract worker for temporary staffing needs for positions covered by the IBEW Physical Agreement or by the ESC Agreement.

A contractor option is not available under the IBEW Clerical Agreement.

Do you have other coverage options outside of PG&E?

- **Are you a veteran?** You may be able to enroll in a Veterans Affairs (VA) plan.
- **Are you not yet eligible for Medicare?** You may qualify for government-subsidized coverage through **coveredca.com** if you live in California—or another health exchange if you live outside California. Visit **healthcare.gov/marketplace-in-your-state** for listings of other states' plans.

Do you have Medicare coverage?

As a Hiring Hall employee, you can:

Keep Medicare as your only coverage	OR	**Keep Medicare and elect the Anthem Gold Plan**	OR	**Disenroll from Medicare and elect the Anthem Gold Plan**
Medicare will be your only source of medical coverage while you're a Hiring Hall employee.		The Anthem Gold Plan will pay your medical bills first, and Medicare will be the secondary payer.		The Anthem Gold Plan will be your only source of medical coverage while you're a Hiring Hall employee.

WATCH OUT!

If you decide to disenroll from Medicare Part B, you'll need to be re-enrolled in Medicare Part B by the time you re-enroll in a PG&E-sponsored retiree medical plan. Otherwise, you'll have to pay the charges Medicare would have covered—**usually about 80% of the bill**—out of your own pocket.

Keep in mind:

- Medicare has specific rules about enrolling and disenrolling. For details, visit **medicare.gov** or call Medicare at **1-800-633-4227**.
- The PG&E-sponsored Medicare Coordination of Benefits (COB) HMOs and Medicare Advantage HMOs have special enrollment rules and deadlines. For details, call the PG&E Benefits Service Center at **1-866-271-8144**.

What happens when your Hiring Hall assignment ends?

Your Anthem Gold Plan coverage will end on the last day of the month your Hiring Hall assignment ends. You must contact the PG&E Benefits Service Center if you wish to reenroll under the PG&E medical plan or COBRA benefits. See below for details.

Are you a Hiring Hall employee with no prior PG&E service?

You won't receive any other PG&E-sponsored health coverage. However, you may elect to receive to extend your Anthem Gold Plan coverage through COBRA.

Are you a surviving spouse or dependent working as a Hiring Hall employee?

You won't be allowed to re-enroll in a PG&E-sponsored retiree medical plan after your Hiring Hall assignment ends. However, you may elect to receive to extend your Anthem Gold Plan coverage through COBRA.

Are you a PG&E retiree—and also a surviving spouse working as a Hiring Hall employee?

You will be allowed to re-enroll in a PG&E-sponsored retiree medical plan after your Hiring Hall assignment ends. That's because you're a PG&E retiree eligible for your own PG&E-sponsored retiree medical coverage.

EXAMPLE: You and your spouse were both PG&E retirees eligible for your own PG&E-sponsored retiree medical coverage. Instead of enrolling as a retiree, you enrolled as a dependent in your spouse's plan. After your spouse died, you went to work as a Hiring Hall employee, and your PG&E-sponsored retiree medical coverage ended.

Because you're a PG&E retiree eligible for your own PG&E-sponsored retiree medical coverage, you can re-enroll in a PG&E-sponsored retiree medical plan after your Hiring Hall assignment ends.

Are you going back to work as a regular employee and electing employee coverage?

Your employee coverage will start the first of the month following your regular employee hire date.

See **Going back to work as a regular employee?** on page 21 for details.

Are you eligible for PG&E-sponsored retiree medical coverage?

You and your eligible dependents will be able to re-enroll in a PG&E-sponsored retiree medical plan. **You'll receive a Personalized Enrollment Worksheet** at your home address with instructions on how to enroll online through your myPlans Connect account or by phone at **1-866-271-8144.**

The rules are a little different based on whether you enrolled in the Anthem Gold Plan as a Hiring Hall employee versus if you didn't.

Want retiree medical coverage? You must actively re-enroll.

You need to actively re-enroll for PG&E-sponsored retiree medical coverage when your Hiring Hall coverage ends. **Re-enrollment is not automatic**. See page 21 for details.

If you enrolled in the Anthem Gold Plan

- Your Anthem Gold Plan coverage **will end on the last day of the month** your Hiring Hall assignment ends.
- You have **31 days from the date your Anthem Gold Plan coverage ends** to re-enroll in a PG&E-sponsored retiree medical plan for yourself and your eligible dependents. **You must actively re-enroll** if you want retiree medical coverage. **Re-enrollment is not automatic**.
- Your retiree medical coverage **generally will start retroactively on the first day of the month** after your Anthem Gold Plan coverage ends.

EXAMPLE—IF YOU ENROLLED IN THE ANTHEM GOLD PLAN

This example generally applies to most PG&E-sponsored retiree medical plans except the Medicare COB and Medicare Advantage HMOs.*

- Your Hiring Hall assignment ends April 28.
- Your Anthem Gold Plan coverage ends April 30 (last day of the month your assignment ends).
- You re-enroll for retiree medical coverage May 15 (which is within 31 days of April 30).
- Your retiree medical coverage will be effective retroactive to May 1.

If you did NOT enroll in the Anthem Gold Plan—and you're eligible for PG&E-sponsored retiree medical coverage

- You have **31 days from your Hiring Hall assignment end date** to re-enroll in a PG&E-sponsored retiree medical plan for yourself and your eligible dependents. **You must actively re-enroll** if you want retiree medical coverage. **Re-enrollment is not automatic**.
- Your retiree medical coverage **generally will start retroactively on the first day of the month** after your assignment end date.

EXAMPLE—IF YOU DID NOT ENROLL IN THE ANTHEM GOLD PLAN

This example generally applies to most PG&E-sponsored retiree medical plans except the Medicare COB and Medicare Advantage HMOs.*

- Your Hiring Hall assignment ends February 25.
- You re-enroll for retiree medical coverage March 8 (which is within 31 days of February 25).
- Your retiree medical coverage will be effective retroactive to March 1.

***Call the PG&E Benefits Service Center right away** if you want to re-enroll in a Medicare COB or Medicare Advantage HMO—Blue Shield Medicare COB HMO, Health Net Medicare COB HMO, Kaiser Permanente Senior Advantage or Health Net Seniority Plus.

In order to re-enroll in one of these plans, you must have Medicare and you must assign it to the plan **before** the effective date of the coverage. Call **1-866-271-8144** for details.

Do you have a Retiree Health Account?

You have this tax-free health reimbursement account if you:

- Were eligible for PG&E-sponsored retiree medical coverage before becoming a Hiring Hall employee; AND
- Were enrolled in the Anthem or Kaiser Health Account Plan (HAP) and had leftover Health Account credits when you retired; OR
- Were a Management, A&T or ESC-represented employee retiring after January 1, 2017, with Capped Sick Time (25% of your Capped Sick Time balance was converted as credits to your Retiree Health Account). IBEW- and SEIU-represented employees do not have Capped Sick Time.

For details about how to use your Retiree Health Account, including eligible expenses, how to file claims and how to track your Retiree Health Account balance, **visit mypgebenefits.com > Financial Health > Retirement > Retiree Medical > Retiree Health Account Cheat Sheet**.

Can you use your Retiree Health Account as a Hiring Hall employee?

Your Retiree Health Account will be suspended while you're a Hiring Hall employee, and you won't be able to use it. However, it will be waiting for you and ready to use when your Hiring Hall assignment ends, and you go back to your retiree status.

When you return to retiree status, you'll be able to use your Retiree Health Account to help pay for:

- Health care premiums—including PG&E-sponsored retiree medical premiums
- Medicare Part B premiums
- Eligible medical, prescription, dental, vision and mental health expenses
- Your dependents' eligible health expenses—even if they're not enrolled in a PG&E-sponsored plan

PG&E won't contribute to your Retiree Health Account after you retire, but you can use your account until your credits are used up. You'll get more details about your Retiree Health Account when you return to retiree status.

Were you NOT eligible for PG&E-sponsored retiree medical coverage before you came back to work as a Hiring Hall employee?

If you're not eligible for PG&E retiree medical coverage, you're not eligible for a Retiree Health Account—even if you had leftover Health Account credits or remaining Capped Sick Time when you retired.

For all Hiring Hall employees: Voluntary Plan and Commuter Transit coverage will end

When your Hiring Hall assignment ends, your PG&E Voluntary Plan and Commuter Transit coverage also will end.

If you go to work for another company, you may be covered by California's State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan") or your new employer's Voluntary Plan, if applicable. In some cases, you may be eligible for State Plan benefits even if you're unemployed.

 **If you participate in the Commuter Transit program, be sure to estimate carefully.**

No refunds will be given for excess Commuter Transit contributions after your Hiring Hall assignment ends.

Going back to work as a regular employee?

If you go back to work for PG&E as a regular employee and you enroll for employee health coverage, your employee coverage will start on the first of the month following the date you become a regular employee—even if you waived Hiring Hall medical coverage. This means you could have a period of time without coverage after you become a regular employee.

If you have Hiring Hall medical coverage when you become a regular PG&E employee, your Hiring Hall coverage will end on the last day of the month in which you become a regular employee—even if you waive employee coverage.

EXAMPLE: When employee coverage starts, and Hiring Hall coverage ends

July 10	Regular employee hire date (the date you become a regular employee)
July 31	Hiring Hall medical coverage ends
August 1	Employee health coverage starts

If you waive employee coverage, you'll have no medical coverage through PG&E.

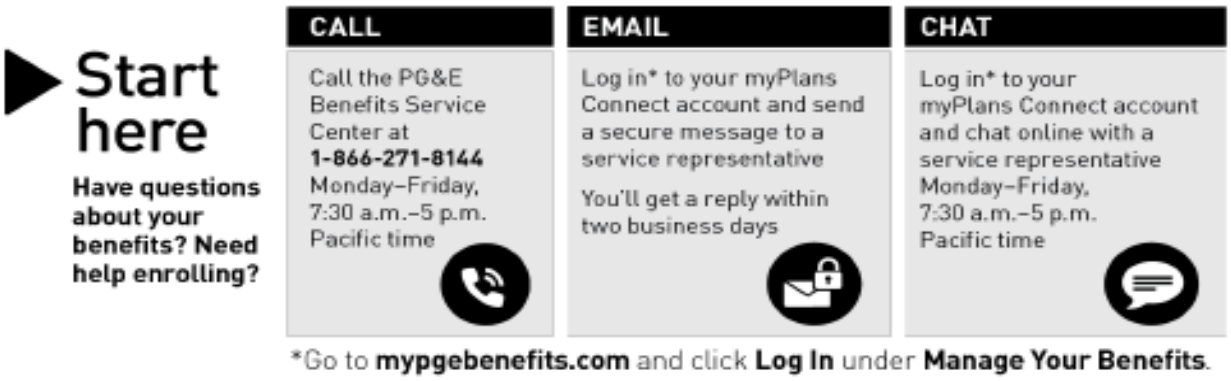
Glossary

Balance billing	If your out-of-network expenses exceed the plan's maximum allowed amount, your doctor may bill you for the difference between his or her charge and the plan's allowed amount. This is called balance billing. These excess amounts don't count toward the annual deductible or out-of-pocket maximum. In-network or preferred providers have agreed to accept the plan's contracted rates for covered services. But you might get a bill from non-network or non-preferred providers—because they haven't agreed to accept the plan's maximum allowed amount for covered services. **EXAMPLE** If your doctor charges $100 for a service and the maximum allowed amount is $60, your doctor may bill you for the remaining $40. You'll be responsible for paying the $40 in addition to any deductible, copayment or coinsurance you may owe.
Chronic condition	An ongoing physical or mental condition that requires long-term monitoring or management to control symptoms. Rheumatoid arthritis is an example of a chronic condition.
Coinsurance	Your share of the cost of covered health services after you pay the annual deductible. Coinsurance is usually 10% to 20% of the allowed amount under the Anthem Gold Plan. See the chart starting on page 14 for details about your benefits.
Copayment or Copay	A copayment is a fixed amount you pay—for example, $10 or $20—at the time of service. **The Anthem Gold Plan does not have copayments.**
Covered services	Health services covered by the plan. Charges for covered services are eligible expenses—up to the contracted or maximum allowed amount.
Deductible	The amount you have to pay every year for covered services before the plan pays benefits for covered services. See page 13 for details.
Durable medical equipment	Equipment or supplies ordered by a health care provider for everyday or extended use. **EXAMPLE** Walkers, wheelchairs and oxygen equipment are all examples of durable medical equipment.
Eligible expense	An expense covered by the plan. Eligible expenses are those that the plan considers medically necessary and that do not exceed the negotiated rate (for preferred providers) or the reasonable and customary cost levels (for out-of-network providers). Expenses that don't meet this definition are not covered by the plan.
Explanation of Benefits (EOB)	After you visit the doctor, you'll get a statement in the mail—an Explanation of Benefits (EOB)—from your claims administrator. The EOB will show how much the plan paid for your treatment or service, and how much you owe. **Always keep your EOBs.** You may need them to question a charge.
Generic	Generic drugs have the same active ingredients as brand-name drugs, and they're subject to the same FDA standards. Generic drugs generally cost less because the generic drug is not under patent.

In-network providers or Network providers or Preferred providers	Licensed health care providers (doctors, hospitals, medical groups) that charge lower rates negotiated by the health plan claims administrator—and that meet quality standards required by the claims administrator. Network providers agree to accept as payment in full the plan's negotiated rates for services and treatment.
Maintenance medications	Medications that require regular, ongoing use to treat long-term or chronic conditions, such as asthma, diabetes, high blood pressure and high cholesterol.
Maximum allowed amount	The maximum allowed amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies. When your out-of-network provider charges more than the plan's maximum allowed amount, you have to pay the difference. These excess charges won't count toward the annual deductible or out-of-pocket maximum. In-network or preferred providers have agreed to accept the plan's contracted rates for covered services, so you won't have charges that exceed the allowed amounts. See **balance billing**. **EXAMPLE** Suppose your plan allows $100 for a specialist office visit but your out-of-network doctor charges $150. You'll have to pay the extra $50—plus any amounts you owe for the office visit. The extra $50 won't count toward your deductible or out-of-pocket maximum.
Out-of-network providers or Non-network providers or Non-preferred providers	Licensed health care providers (doctors, hospitals, medical groups) that have not signed a contract with a health care claims administrator to provide services at a reduced negotiated rate. Non-network providers may charge more than the plan's maximum allowed amount. As a patient, you're responsible for paying any amounts charged by out-of-network providers that exceed the allowed amount. Charges that exceed the maximum allowed amount don't count toward the annual deductible or out-of-pocket maximum.
Out-of-pocket maximum	The most you'll have to pay for covered services in a calendar year. After you spend this amount on deductibles and coinsurance, the plan will pay 100% of the cost of eligible expenses for the rest of the year. The out-of-pocket maximum doesn't include amounts you pay for premiums, services that aren't covered or out-of-network charges that exceed the allowed amount.
Premium	The monthly amount charged for health care coverage. You and PG&E share the cost of premiums.
Preventive care	Care that focuses on disease prevention and health maintenance, including early diagnosis of health problems.
Primary care	Basic or general health care provided when you first seek care from a doctor. The Anthem Gold Plan provides four free primary care visits per year per enrolled person. See page 14 for details.

Primary care physician (PCP) **or** **Primary care provider (PCP)**	The doctor, nurse practitioner or physician assistant who provides or coordinates your care, referring you to specialists when needed.
Provider	Licensed health care professional or facility, including doctors, nurse practitioners, physician's assistants, hospitals, clinics, medical groups, pharmacies, durable medical equipment providers, labs and other licensed health care providers.
Retiree Heath Account For details about how to file claims, go to **mypgebenefits.com > Financial Health > Retirement > Retiree Medical > Retiree Health Account Cheat Sheet**.	Did you retire in 2013 or later—and were you eligible for PG&E-sponsored retiree medical coverage? You may have a Retiree Health Account. PG&E set up and funded your Health Account while you were an employee enrolled in the Anthem or Kaiser HAP. When you retired, PG&E stopped funding your Health Account, and—if you were eligible for PG&E-sponsored retiree medical coverage—transferred any unused credits in your Health Account to a Retiree Health Account, provided you were enrolled in the HAP when you retired. In addition, if you were a Management, A&T or ESC-represented employee who retired after January 1, 2017, with Capped Sick Time, 25% of your Capped Sick Time balance was converted as credits to your Retiree Health Account even if you weren't enrolled in the HAP when you retired. IBEW- and SEIU-represented employees do not have Capped Sick Time. You can use your Retiree Health Account to help pay for health care premiums (including PG&E-sponsored retiree medical premiums), Medicare Part B premiums and eligible medical, dental, vision and mental health expenses. You can also use your Retiree Health Account to help pay for your dependents' eligible health expenses—even if they're not enrolled in a PG&E-sponsored plan.
Urgent care	An office visit at an urgent care center when your primary care physician is not available—or when you need a same-day appointment. Urgent care typically is for an illness or injury that is not life threatening. The Anthem Gold Plan covers urgent care visits as primary care. An urgent care visit can be counted as one of your four free primary care visits. **Avoid emergency room rates for urgent care.** Some hospitals advertise themselves as urgent care centers when in fact, they're not—and they charge higher emergency room rates. **Always check to see if the facility you want to use is really an urgent care center:** Call Anthem Blue Cross or use the "Find a Doctor" feature on **anthem.com/ca/pge**.
Voluntary Plan	If you're an eligible California Utility employee, you're automatically covered under PG&E's Voluntary Disability and Paid Family Leave Benefit Plan (the "Voluntary Plan"). You can opt in or out of the Voluntary Plan anytime through your myPlans Connect account. Changes will be effective on the first day of the month of the following quarter— or on the first day of the month following the second quarter if you initially rejected Voluntary Plan coverage. For details about when coverage changes will be effective, visit **mypgebenefits.com > Time Off and Accommodations > Voluntary Plan**. The Voluntary Plan provides better benefits and is offered in place of California's State Disability Insurance (SDI) and Paid Family Leave plan (the "State Plan").

Contact information



Medical coverage

I NEED TO:

- Talk to Member Services about my benefits
- Find out if my provider belongs to the plan's network
- Preauthorize care
- Get an Anthem Gold Plan ID card

MEDICAL	CONTACT	GROUP NUMBER
Anthem Gold Plan Representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific time	**1-800-964-0530** **anthem.com/ca/pge** **Sydney app**	170157
For chiropractic and acupuncture preauthorization required after five visits: **American Specialty Health Network (ASH)**	**1-800-678-9133**	N/A

Prescription drug coverage

I NEED TO:

- Find out if my prescription drug is covered
- Get help with a claim
- Get an Express Scripts ID card

PRESCRIPTION DRUG	CONTACT	GROUP NUMBER
Administered by Express Scripts Representatives are available 24/7; closed Thanksgiving and Christmas	**1-800-718-6590** **express-scripts.com** **Express Scripts app**	PGE0000

Mental health and substance use disorder coverage

I NEED TO:

- Find out if my treatment is covered
- Request preauthorization
- Get help with a claim

MENTAL HEALTH & SUBSTANCE USE DISORDER	CONTACT
Administered by Beacon Health Options Representatives are available 24/7	**1-888-445-4436** **beaconhealthoptions.com**

COBRA

I NEED TO:

Continue Anthem Gold Plan coverage through COBRA after my Hiring Hall coverage ends

COBRA	CONTACT
Administered by HealthEquity I WageWorks Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific time	**1-866-271-8144** **Option 3** **healthequity.com/wageworks**

Form 1095

I NEED TO:

Get a copy of my Form 1095 to verify that I had minimum essential health coverage

Anthem Gold Plan	CONTACT
PG&E Benefits Service Center Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific time	**1-866-271-8144**

More details

I NEED TO:

Read details about my benefits

Summary of Benefits Handbook
1-866-271-8144 to request a free copy Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific time **spd.mypgebenefits.com**

Summary of Material Modifications (October 2020)

This *2021 Benefits* guide is for Hiring Hall employees. It is designed, in part, to make you aware of important changes that have been made to The Pacific Gas and Electric Company Health Care Plan for Active Employees (the "Health Care Plan" or "Plan").

Your enrollment materials are not an exhaustive explanation of the Health Care Plan. Additional information about the Plan is contained in the document entitled, *The Pacific Gas and Electric Company Health Care Plan for Active Employees*. That document, the *Summary of Benefits Handbook* and any summaries of material modifications (SMMs), including enrollment guides designated as SMMs, collectively constitute the respective official plan documents. You can find them at **mypgebenefits.com > Resources > Summary of Benefits Handbooks**.

The Employee Benefit Committee of PG&E Corporation is the Plan Administrator of the Plan, and has the discretionary authority to interpret and construe the terms of the official Plan documents, to resolve any conflicts or discrepancies between the documents that comprise the official Plan documents and to establish rules that are necessary for the administration of the Plan.

Unless otherwise noted, references to PG&E in this guide and in other benefits materials mean Pacific Gas and Electric Company. Pacific Gas and Electric Company, PG&E Corporation and their affiliates are referred to collectively as "Participating Employers."

Pacific Gas and Electric Company has the right to amend or terminate the Plan at any time and for any reason, subject to notice provisions if such notice is required under applicable collective bargaining agreements. Generally, an amendment to or termination of the Plan will apply prospectively and will affect your rights and obligations under the Plan prospectively.