2021

Legal Information

This booklet contains legally required information and annual notices for PG&E employees and retirees who are eligible for PG&E-sponsored health care coverage.

Please keep this booklet in a safe place for future reference. This is not part of Open Enrollment; it's simply legal information PG&E is required to distribute annually.

Medicare Coverage

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the Medicare Part D notice on page 10 for information about your prescription drug coverage and Medicare.

TAX INFORMATION FOR DOMESTIC PARTNERS

Many registered domestic partners do not qualify as tax dependents. However, if your enrolled, registered domestic partner or his or her enrolled children are your tax dependents, and you have certified them as tax dependents by calling the PG&E Benefits Service Center, the value of the health care benefits will not be reported as taxable income.

Tax Information

DOMESTIC PARTNER REGISTRATION

If you want to add a domestic partner or the children of a domestic partner to your coverage, your partnership must be registered with a governmental agency that maintains a domestic partner registry. You'll also need to provide verification of your domestic partner, as requested.

TAX IMPLICATIONS OF COVERAGE FOR YOUR SAME-SEX SPOUSE, REGISTERED DOMESTIC PARTNER, AND CHILDREN OF YOUR SAME-SEX SPOUSE OR REGISTERED DOMESTIC PARTNER

Federal Tax Treatment of Benefits for Same-Sex Spouses

Same-sex spouses are treated as married for all federal tax purposes. This applies to any same-sex marriage legally entered into in one of the 50 states, the District of Columbia, a U.S. territory or a foreign country. The value of the health care coverage provided for a same-sex spouse or any enrolled children of a same-sex spouse is not treated as income to you for federal tax purposes.

Federal Tax Treatment of Benefits for Domestic Partners

The rules on taxation of benefits for legally married same-sex spouses do not apply to domestic partnerships.

The value of the health care coverage provided for a registered domestic partner or any enrolled children of a registered domestic partner is treated as income to you for federal tax purposes. PG&E will report the value of the coverage as income on your Form W-2 and will withhold federal income and employment taxes. The amounts taxable to you can be substantial.

An exception to these income reporting and withholding rules applies if your registered domestic partner or children of your registered domestic partner are your tax dependents under Internal Revenue Code sections 152 and 105(b). Please contact your tax advisor or call the PG&E Benefits Service Center for more information.

California Taxes

For California income tax purposes, the value of the health care benefits provided to your same-sex spouse and your same-sex spouse's dependents are excluded from your taxable income.

For California income tax purposes, the value of the health care benefits provided to your domestic partner and your domestic partner's dependents may be excluded from your taxable income if your partnership is registered with California's Secretary of State and if certain other conditions are met. Please contact your tax advisor or call the PG&E Benefits Service Center for more information.

Other states have their own tax rules for health care benefits provided to domestic partners, same-sex spouses and dependents of domestic partners or same-sex spouses. If you live outside California, consult a tax advisor.

More Information About Registered Domestic Partners

Do you need more details? Please call the PG&E Benefits Service Center for more information about domestic partner registration and health benefits for registered domestic partners.

HIPAA Special Enrollment Rights for Employees

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline PG&E-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan if you're an employee and:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents meet or exceed the lifetime limit on benefits payable under the other plan
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP

In addition, if you're an employee, you may be able to enroll yourself and your dependents in a PG&E-sponsored health care plan when:

- You have a newly eligible dependent due to marriage, establishment of a registered domestic partnership, birth, adoption or placement for adoption of a child

You must request enrollment by calling the PG&E Benefits Service Center:

- **Within 31** days after the other coverage ends or the employer stops contributing to the other coverage
- **Within 31** days of your marriage or domestic partnership registration
- **Within 180** days of the birth, adoption or placement for adoption of a child (60 days for Kaiser Senior Advantage plan)
- **Within 60** days of the Medicaid/CHIP eligibility change

NOTE: To complete the enrollment process, you'll be required to provide verification of your dependents' eligibility.

For more information or to request special enrollment, visit **myPlansConnect**® (formerly Mercer BenefitsCentral) or call the PG&E Benefits Service Center.

TEMPORARY EXTENSION FOR HIPAA SPECIAL ENROLLMENT DEADLINES

Due to the COVID-19 national emergency, the deadlines for requesting HIPAA special enrollment in a PG&E-sponsored health plan have been extended to:

- 60 days after the announced end of the COVID-19 national emergency, or
- Until another date as announced in a future notification.

Important Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

Coverage of breast reconstruction will be provided subject to the deductibles and coinsurance benefit limits consistent with those established for other benefits under your plan. For more information, contact your medical plan directly.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

LANGUAGE ASSISTANCE

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 lingüística. 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)**.

HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This version of the notice is effective September 1, 2020. Please review it carefully.

This notice is required by the Health Insurance Portability and Accountability Act ("HIPAA") and is intended to describe to the extent applicable to you how the Pacific Gas and Electric Company Health Care Plan for Active Employees, the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and the Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plans"), and the various health plan vendors that administer these Health Plans (for example, Anthem Blue Cross) will protect your health information. This notice also describes your rights to access and control your protected health information.

"Health information" for this purpose means information that identifies you and either relates to your physical or mental health condition or the provision of health care to you, or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed by the Health Plans without a written authorization from you, except as described in this notice or as otherwise permitted by federal or state health information privacy laws. Please note that your personal physician or other health care facilities (for example, hospitals or health clinics) where you may receive health care or treatment may have different policies, procedures or notices regarding the physician's or health care facility's use or disclosure of PHI that they may have created. These health care providers and any health plan insurer will separately notify you regarding their health information policies or procedures.

SUMMARY

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask the Health Plans to limit the information shared
- Get a list of those with whom the Health Plans have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that the Health Plans use and share information to:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market Health Plan services and sell your information

Our Uses and Disclosures

The Health Plans may use and share your information to:

- Help manage the health care treatment you receive
- Run the Health Plans' organizations
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

DETAILS

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of the Health Plans' responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information the Health Plans have about you—except for psychotherapy notes; information intended for use in a civil, criminal or administrative proceeding; or any information to which access is otherwise prohibited by law. Contact the PG&E Benefits Service Center to request this information. Ask your health plan(s) how to do this.
- The Health Plans will provide a copy or a summary of your health and claims records, usually within 30 days of your request. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline. In limited situations, the Health Plans may say "no" to your request, but will tell you why in writing and may charge a reasonable, cost-based fee.

Ask the Health Plans to correct health and claims records

- You can ask your health plan(s) to correct your health and claims records if you think they are incorrect or incomplete. Ask your health plan(s) how to do this.
- The Health Plans may say "no" to your request, but will tell you why in writing within 60 days. A single, 30-day extension is allowed if the Health Plans cannot comply by the initial deadline.

Request confidential communications

- You can ask to be contacted in a specific way (for example, home or office phone) or to send mail to a different address.
- The Health Plans will consider all reasonable requests, and must say "yes" if you tell your health plan(s) you would be in danger otherwise.
- To request confidential communications, make your request in writing to:

  Pacific Gas and Electric Company
  HIPAA Privacy Official
  77 Beale St.
  P.O. Box 770000
  San Francisco, CA 94177
  Email: **pgeprivacy@pge.com**
- The Health Plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

State privacy rights

You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

Ask the Health Plans to limit what the Health Plans use or share

- You can ask the Health Plans not to use or share certain health information for treatment, payment, or Health Plans' operations.
- The Health Plans are not required to agree to your request, and may say "no" if it would affect your care.

Get a list of those with whom the Health Plans have shared information

- You can ask for a list (accounting) of the times the Health Plans have shared your health information for six years prior to the date you ask, who the Health Plans shared it with, and why.
- The Health Plans will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Health Plans to make). The Health Plans will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time by calling the PG&E Benefits Service Center at **1-866-271-8144**, even if you have agreed to receive the notice electronically. The Health Plans will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Health Plans will make sure the person has this authority and can act for you before taking any action.

File a complaint if you feel your rights are violated

- You can complain if you feel the Health Plans have violated your rights by contacting:

  Pacific Gas and Electric Company
  HIPAA Privacy Official
  77 Beale St.
  P.O. Box 770000
  San Francisco, CA 94177
  Email: **pgeprivacy@pge.com**

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
  - Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
  - Calling **1-877-696-6775**; or
  - Visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- The Health Plans will not retaliate against you for filing a complaint. The complaint should generally be filed within 180 days of when the act or omission complained of occurred.

Your Choices

For certain health information, you can tell the Health Plans your choices about what the Health Plans share. If you have a clear preference for how the Health Plans share your information in the situations described below, talk to the Health Plans. Tell the Health Plans what you want done, and the Health Plans will follow your instructions.

In these cases, you have both the right and choice to tell the Health Plans to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell the Health Plans your preference—for example if you are unconscious—the Health Plans may go ahead and share your information if the Health Plans believe it is in your best interest. The Health Plans may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Health Plans *never* share your information unless you give the Health Plans written permission:

- Marketing purposes
- Sale of your information

The Health Plans' Uses and Disclosures

How do the Health Plans typically use or share your health information?

The Health Plans typically use or share your health information in the following ways:

Help manage the health care treatment you receive

The Health Plans can use your health information and share it with professionals who are treating you.

Example: A doctor sends your health plan(s) information about your diagnosis and treatment plan so your health plan(s) can arrange additional services.

Run the Health Plans' organizations

- The Health Plans can use and disclose your information to run the Health Plans' organizations and contact you when necessary.
- The Health Plans are not allowed to use genetic information to decide whether the Health Plans will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: The Health Plans use health information about you to develop better services for you.

Pay for your health services

The Health Plans can use and disclose your health information as the Health Plans pay for your health services.

Example: The Health Plans share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

The Health Plans may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with the Health Plans to provide health benefits, and the Health Plans provide your company with certain statistics to explain the premiums the Health Plans charge.

How else can the Health Plans use or share your health information?

The Health Plans are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. The Health Plans have to meet many conditions in the law before your information can be shared for these purposes. For more information, see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

The Health Plans can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

The Health Plans can use or share your information for health research.

Comply with the law

The Health Plans will share information about you if local, state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Health Plans are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Health Plans can share health information about you with organ procurement organizations.
- The Health Plans can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Health Plans can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

The Health Plans can share health information about you in response to a court or administrative order, or in response to a subpoena, warrant, discovery request, or other forms of lawful due process.

The Health Plans' Responsibilities

- The Health Plans are required by law to maintain the privacy and security of your protected health information.
- The Health Plans will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Health Plans must follow the duties and privacy practices described in this notice and give you a copy of it.
- The Health Plans will not use or share your information other than as described here unless you tell a Health Plan it can in writing. If you tell a Health Plan it can use or share your information, you may change your mind at any time. Let the Health Plans know in writing if you change your mind.

For more information, see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Changes to the Terms of this Notice

The Health Plans can change the terms of this notice, and the changes will apply to all information the Health Plans have about you. The new notice will be available upon request on the Health Plans' websites, and a copy will be mailed to you unless you had agreed to receive the notice electronically, or unless you are able to receive electronic information at your worksite.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are ***not*** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your state for more information on eligibility.

The following is a partial list of participating states.

CALIFORNIA—Medicaid
Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: **916-440-5676**

NEVADA—Medicaid
Website:
http://dhcfp.nv.gov/
Phone: **1-800-992-0900**

OREGON—Medicaid
Websites:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: **1-800-699-9075**

TEXAS—Medicaid
Website:
http://gethipptexas.com/
Phone: **1-800-440-0493**

VIRGINIA—Medicaid and CHIP
Website:
https://www.coverva.org/hipp/
Medicaid Phone: **1-800-432-5924**
CHIP Phone: **1-855-242-8282**

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

PACIFIC GAS AND ELECTRIC COMPANY MEDICARE PART D CREDITABLE COVERAGE NOTICE

Medicare-Eligible Participants: Important Notice About Your Prescription Drug Coverage and Medicare

This is a legally required notice that PG&E must provide annually to all employees, retirees and surviving dependents eligible for PG&E-sponsored medical coverage. Please read this notice and keep it where you can find it. No other action is required.

This notice has information about your current prescription drug coverage under plans sponsored by Pacific Gas and Electric Company (PG&E) and your options under Medicare's prescription drug coverage (called Part D). This information can help you decide if you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PG&E has determined that the prescription drug coverage offered by the Pacific Gas and Electric Company Health Care Plan for Active Employees and by the Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you enroll in a Medicare drug plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your PG&E-sponsored coverage or if you lose your current creditable prescription drug coverage through no fault of your own, you also will be eligible for a two-month Special Enrollment Period (SEP) to enroll in a Medicare drug plan.

What will happen to your current medical coverage if you decide to enroll in a Medicare drug plan?

Prescription drug coverage is included in all PG&E-sponsored medical plans. Every medical plan that PG&E currently offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Medicare Part D benefit.

If you decide to enroll in a Medicare drug plan that is not sponsored by PG&E (in other words, a plan not offered by PG&E during the enrollment period), **your PG&E-sponsored medical and prescription drug benefits will be terminated**.

Can you re-enroll in a PG&E-sponsored medical plan at a later date?

Eligible retirees and employees on Long-Term Disability who enroll themselves and their dependents in a non-PG&E Medicare drug plan will not be able to re-enroll in a PG&E-sponsored medical plan until the next Open Enrollment.

Surviving dependents who enroll in a non-PG&E Medicare drug plan will not be able to re-enroll in a PG&E-sponsored plan at any time.

PG&E-sponsored medical plans with prescription drug coverage and Medicare Advantage Plans are available during Open Enrollment for eligible retirees, currently enrolled surviving dependents and employees on Long-Term Disability.

When will you pay a higher premium (penalty) to enroll in a Medicare drug plan?

If you drop or lose your current PG&E coverage and you don't enroll in a Medicare drug plan within 63 continuous days after your PG&E-sponsored coverage ends, you may have to pay a higher premium (a penalty) to later enroll in a Medicare drug plan.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Where can you find more information about PG&E-sponsored coverage?

For more information about this notice or your current PG&E-sponsored prescription drug coverage, log in to your **myPlansConnect**® account (formerly Mercer BenefitsCentral) or call the PG&E Benefits Service Center. **Note:** You'll get this notice each year before the next period you can enroll in a Medicare drug plan. You'll also get this notice if PG&E-sponsored prescription drug coverage changes. You may request a copy of this notice at any time.

Where can you find more information about your options for Medicare prescription drug coverage?

Detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You also may be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- For personalized help, call your state Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number).
- Call **1-800-633-4227 (1-800-MEDICARE)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit **www.socialsecurity.gov** or call **1-800-772-1213 (TTY 1-800-325-0778)**.

September 2020
Pacific Gas and Electric Company
Benefits Department
P.O. Box 5546
Concord, CA 94524

KEEP THIS CREDITABLE COVERAGE NOTICE

This is a legally required notice about your benefits. Please read this notice carefully and keep it where you can find it.

If you decide to enroll in a Medicare drug plan, you may be required to provide a copy of this notice when you enroll to show that you have maintained creditable coverage. If you have maintained creditable coverage, you will not be required to pay a higher premium (a penalty).

NOTICE REGARDING WELLNESS PROGRAM

PG&E's health screening program is a voluntary wellness program available to all employees that are eligible for the Health Account Plan (HAP). The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee (an individual's) health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a health screening, which will include a blood test for total cholesterol, HDL, TC/HDL cardiac ratio, and glucose, as well as tests for blood pressure, height, weight, BMI and body fat percentage. You are not required to participate in the blood test or other medical examinations.

Employees who choose to participate in the wellness program will receive incentives paid through a health reimbursement account (HAP credits of up to an additional $500 for single coverage or $1,000 for family coverage) for completing a health screening and testing tobacco-free or completing Quest Diagnostics' free telephonic tobacco cessation program. Although you are not required to participate in the health screening, tobacco-free test, or tobacco cessation program, only employees (individuals) who do so will receive the full incentive amount. If you are unable to participate in any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Quest Diagnostics at **1-866-271-8144**, option 1 then option 3, or at **wellness@questdiagnostics.com**.

The results from your health screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and PG&E may use aggregate information they collect to design a program based on identified health risks in the workplace, Quest Diagnostics will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program, unless you authorize other health care providers to view this information.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision in regards to you. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the PG&E Benefits Service Center at **1-866-271-8144**.

BEACON HEALTH OPTIONS OF CALIFORNIA, INC., GRIEVANCE PROCESS

California employees covered under an Employee Assistance Program administered by Beacon Health Options of California, Inc. (Beacon of California) (a subsidiary of Beacon Health Options, Inc.) regulated by the California Department of Managed Health Care (DMHC), are entitled to receive notification of the Beacon of California grievance process.

The process outlines standard procedures for filing a grievance with Beacon of California and also includes instructions for requesting expedited review of urgent grievances or requests for mediation or arbitration. You may also request an independent medical review (IMR) of Disputed Behavioral Health Care Services from the Department of Managed Health Care if you believe that behavioral health care services have been improperly denied, modified, or delayed by Beacon of California. The Beacon of California Grievance Process provides information about how to submit such a request.

Beacon of California is committed to providing excellent Employee Assistance Services and to ensuring a positive member experience. Should you have any questions regarding this protocol, please feel free to contact Beacon of California at **1-800-228-1286, extension 262422 (TTY 1-800-735-2929)**.

Grievance Definition

A grievance is a written or oral expression of dissatisfaction regarding Beacon of California and/or a provider, including quality of care concerns, complaints, disputes, requests for reconsideration or appeals made by a member (meaning your or your eligible family members) or the member's representative.

Grievance Process

Beacon of California has a grievance procedure for receiving and resolving your grievances involving Beacon of California and providers. A grievance may be submitted up to 180 calendar days following receipt of an adverse determination notice, or following any incident or action that is the subject of the member's dissatisfaction. You may submit a grievance to Beacon of California in writing, in person, by telephone, by facsimile, by email (**CAComplaints@beaconhealthoptions.com**), or online at **beaconhealthoptionsca.com** or, upon request, we will mail a grievance form and a copy of our Grievance Procedure. If you wish, a customer service representative will assist you in completing the grievance form.

To submit a grievance, you may call us at **1-800-228-1286**. Completed grievance forms may be submitted online through a secure means at **beaconhealthoptionsca.com** or may be mailed or delivered to Beacon of California, ATTN: Grievance Unit, P.O. Box 6065, Cypress, CA 90630-0065.

We will send you written acknowledgment of receipt of a grievance within five (5) calendar days. We will respond in writing with a resolution to a grievance within thirty (30) calendar days of receipt.

Urgent Grievances

Beacon of California also maintains a process for the expedited review of urgent grievances. You have the right to an expedited review for cases involving an imminent and serious threat to the health of the member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by you or by your provider. Call **1-800-228-1286** and tell the representative that you are requesting an expedited review for an urgent grievance. We will notify your provider of the decision in no more than 72 hours and send you a written statement on the disposition or pending status of the grievance within the same 72 hours from receipt of the grievance.

Additional Review

If you are not satisfied with our response to a grievance, you may submit a request to Beacon of California for voluntary mediation or binding arbitration within sixty (60) days of receipt of our response. These processes are described in your Combined Evidence of Coverage and Disclosure Form or you may call us for information on how to submit a voluntary mediation or arbitration request.

You may file a grievance with the Department of Managed Health Care after completing the Beacon of California grievance process or voluntary mediation or after participating in the Beacon of California grievance process or voluntary mediation for thirty (30) days.

Independent Medical Review

You may request an independent medical review (IMR) of Disputed Behavioral Health Care Services from the Department of Managed Health Care if you believe that behavioral health care services have been improperly denied, modified, or delayed by Beacon of California. A "Disputed Behavioral Health Care Service" is any mental health or substance abuse care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by Beacon of California, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Beacon of California will provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays behavioral health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Beacon of California regarding the Disputed Behavioral Health Care Service.

The IMR process is described in your Combined Evidence of Coverage and Disclosure Form or you may call us for information on how to submit an IMR request.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Beacon of California, you should first telephone Beacon of California at **1-800-228-1286 (TTY 800-735-2929)** and use Beacon of California's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's website at **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, it introduced a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage effective on or after January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the PG&E Benefits Service Center.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Pacific Gas and Electric Company; PG&E Corporation; PG&E Corporation Support Services, Inc.; PG&E Corporation Support Services II, Inc.		94-0742640*
5. Employer address		**6. Employer phone number**
P.O. Box 5546		1-866-271-8144
7. City	**8. State**	**9. ZIP code**
Concord	CA	94524
10. Who can I contact about employee health coverage at this job?		
PG&E Benefits Service Center		
11. Phone number (if different from above)		**12. Email address**

*Coverage is offered to eligible employees through the Pacific Gas and Electric Company Health Care Plan for Active Employees.

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:
    - **For union-represented employees:** You are eligible to enroll for health care coverage if you are a full-time or part-time Bargaining Unit employee represented by the IBEW, ESC, or SEIU, regardless of whether you are a probationary employee or have reached regular status. You are not eligible to enroll for active employee health care coverage if you are a contract or agency employee, or a retiree of the Company (unless you are a retiree who has been rehired as a regular or Hiring Hall employee). Generally, intermittent employees and other temporary employees who are not expected to become regular employees are also not eligible for coverage, unless treated as full-time during a stability period, based on hours worked in a measurement period, under the Affordable Care Act (ACA).
    - **For Management and A&T employees:** You are eligible to enroll for health care coverage if you are a full-time or part-time Management or Administrative & Technical employee. You are not eligible to enroll for active employee health care coverage if you are a contractor or agency employee, or a retiree of the Company (unless you are a retiree who has been rehired as a regular or Hiring Hall employee).
    - **For Hiring Hall employees:** You are eligible to enroll for medical coverage.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

- Your legally married spouse, legally state-recognized common-law spouse, or registered domestic partner;
- Your children who are under age 26, including stepchildren, children born during a registered domestic partnership, foster children, legally adopted children, and children for whom you have been permanently appointed legal guardianship by a court (does not include the legal wards of your spouse);
- The children of your registered domestic partner who are under age 26, including legally adopted children (for employees and retirees only). Note that a child for whom your registered domestic partner is the legal guardian is not an eligible dependent;
- Your disabled children or those of your spouse/registered domestic partner who are age 26 or older, who are certified as disabled by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who have been approved by a PG&E-sponsored medical plan provider for continued coverage before they reach age 26. For more information, please contact the Member Services department of the medical plan in which you are enrolled; or
- Your family member or registered domestic partner if you both are employees in the same classification (e.g., both Management and A&T employees or both union-represented employees), or you both are retirees. You each have the option of electing coverage as an "employee" or "retiree," or you can be covered as a "dependent" of the other. However, you may not be covered as both. In addition, you may not be covered as both an employee and a retiree. Management and A&T employees may not cover union-represented employees and vice versa.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

PG&E RESOURCES FOR EMPLOYEES AND RETIREES

PG&E Benefits Service Center Help with PG&E-sponsored health benefits and life insurance Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific time **1-866-271-8144**	**myPlansConnect®** (formerly Mercer BenefitsCentral) Login required to access your personal data Help with PG&E-sponsored health benefits and life insurance **mypgebenefits.com** > **Manage Your Benefits**