

WHAT'S INSIDE?

- 1 Welcome**
What's new for 2015?
- 2 Explore**
Wellness program options
- 3 Review**
Coverage options and costs
- 4 Enroll**
What you need to do now
- 5 Remember**
Details about your coverage

Want More Details?

Enrollment Worksheet

Available plans and coverage costs

Medical Plan Comparison Charts

Details about benefits

More Information

Visit [PG&E@Work For Me](#) > [Open Enrollment](#) > [Related Links](#)

Retirees and Surviving Dependents

Open Enrollment is October 23–November 6

Benefits 2015

As a PG&E retiree or surviving dependent, you have the opportunity during Open Enrollment to decide if you want to keep or change your current medical coverage.

If you like what you have, you don't need to do anything. But if you're curious about what else is available, now is the perfect time to consider your options.

No Questions? No Need to Call.

If you're not making any changes to your benefits or if you have no questions, there is no need to call the HR Service Center.

The HR Service Center will be handling a high volume of calls during Open Enrollment. If you do have questions, please submit them via email, if possible: hrcbenefitsquestions@exchange.pge.com

Please allow three full business days for a response. Additional contact information is listed on the back cover.



Summary of Material Modifications (October 2014)

This *Benefits 2015* brochure for Retirees and Surviving Dependents 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 Retirees and Surviving Dependents (referred to as the "Health Care Plan").

Your 2015 enrollment materials are not an exhaustive explanation of the Health Care Plan. Additional information about the Health Care Plan is contained in the documents entitled *The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents*, the *Summary of Benefits Handbook* and the summaries of material modifications (SMMs). Those documents, the enrollment guides designated as SMMs, the summary plan description for the Kaiser EPO, and the evidence of coverage booklets or service provider agreements issued by the HMOs, collectively constitute the official plan document.

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

Unless otherwise noted, references to PG&E in this booklet and in other enrollment 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 Health Care 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 Health Care Plan will apply prospectively and will affect your rights and obligations under the Health Care Plan prospectively.



What's New for 2015?

There are no changes to retiree medical benefits for 2015.

MEDICAL COVERAGE FOR RETIREES IN HIRING HALL

Recent changes in health care reform require that as of January 1, 2015, PG&E retirees working as Hiring Hall employees may no longer have access to their retiree coverage while working as Hiring Hall employees. Instead, PG&E will offer alternate medical coverage. Separate communications will be sent to retirees who will be affected by this requirement.

DO YOU HAVE A NEW ADDRESS OR PHONE NUMBER?

Make sure your home address is correct because the availability of some medical plans is based on where you live. If you've moved or you have a new phone number, please contact the HR Service Center immediately to update your information.

See the back cover for the HR Service Center's contact information.

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 included in the 2015 *Legal Information* booklet that was mailed to you in September. If you need a copy of this notice, contact the HR Service Center.





EXPLORE

Wellness

PG&E's wellness benefits work hand in hand with your medical coverage to help you maintain or improve your health. After all, the important thing is to feel well enough to enjoy life's important events with your friends and family. These resources can help you do that.

<p>Preventive Benefits</p>	<p>Your medical plan offers checkups that can help keep you healthy for the long term:</p> <ul style="list-style-type: none"> • Annual physicals • Routine screenings as recommended by your medical plan—such as colonoscopies, prostate exams, OB/GYN exams and mammograms
<p>Tobacco Cessation</p>	<p>When it comes to quitting smoking or chewing, each person's challenges and needs are unique.</p> <p>Provant Health Solutions offers a free tobacco cessation program for you and your spouse or domestic partner. You'll get a five-week, phone-based program with one-on-one support with a certified tobacco cessation specialist. Nicotine replacement therapy is available to complement the program.</p> <p>To get started, call Provant at 1-866-271-8144. Representatives are available Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.</p> <p>You can start participating in the program anytime; you don't have to wait for 2015.</p>
<p>Free Flu Shots</p>	<p>Anthem members: You can get your seasonal flu shots at no cost at any of the retail pharmacies that sponsor flu shots in the Express Scripts retail pharmacy network. You'll need to have your Express Scripts ID card with you for claims processing.</p> <p>If you get your flu shot at your doctor's office, it will be covered as any other immunization but it won't be free.</p> <p>Blue Shield, Health Net and Kaiser members: You can get your free flu shot from your primary care physician (PCP).</p>



Medical

PG&E offers a variety of medical plan choices that include prescription drug, mental health and substance abuse benefits designed to meet diverse needs. Be sure to see the enclosed Enrollment Worksheet for the specific plans available to you and the 2015 Medical Plan Comparison Charts for details about the benefits available under each plan.

The medical plan options available to you are based on:

- Whether you're eligible for Medicare—and
- Where you live

Some plans provide different benefits to their members after their members reach age 65 or become eligible for Medicare as the result of a disability. The plan names may even change. For example, Health Net's corresponding Medicare Advantage HMO plan is called Seniority Plus.

- 1 **First, review your 2015 Enrollment Worksheet** to see the specific plans available to you and the monthly contributions for each plan.
- 2 **Then, review the chart on the next page** to determine the corresponding medical plan available to any dependents whose eligibility for Medicare is different than your own.

EXAMPLE:

You're eligible for Medicare, but your spouse and children are not. You enroll in the Health Net Seniority Plus plan. Your spouse and children will be enrolled in the Health Net HMO plan.



Medical Plan for Non-Medicare-Eligible Members*	Corresponding Plan for Medicare-Eligible Members*
Anthem Blue Cross Network Access Plan (NAP) or Comprehensive Access Plan (CAP)	Anthem Blue Cross Comprehensive Access Plan (CAP) or Medicare Supplemental Plan (MSP)**
Anthem Blue Cross Retiree Optional Plan (ROP)	Anthem Blue Cross Retiree Optional Plan (ROP)
Blue Shield HMO	Blue Shield Medicare Coordination of Benefits (COB) HMO
Health Net HMO	Health Net Seniority Plus (Medicare Advantage HMO) or Health Net Medicare Coordination of Benefits (COB) HMO
Kaiser Permanente EPO North or South	Kaiser Permanente Senior Advantage North or South (Medicare Advantage HMO)

*Some plans are subject to availability based on your home ZIP code.

**The MSP is not available to Medicare-eligible dependents unless the PG&E retiree is also Medicare-eligible.

ID Cards

If you change medical plans or add dependents, you'll receive your new ID card:

- In January 2015 if you enroll during Open Enrollment
- Within seven days after your change takes effect if you enroll midyear

If you don't receive your new ID card within seven days after the effective date of your change, call your medical plan directly. If you need to see a doctor before your ID card arrives, use your confirmation statement as proof of coverage. Members in the Anthem Blue Cross-administered plans and Health Net HMO plans can print a copy of their ID cards from the plans' websites. Anthem members can also print temporary ID cards for their prescription drug plan coverage at www.express-scripts.com.



If You Move Out of Your Plan's Service Area

You'll be allowed to switch to another PG&E-sponsored medical plan midyear only if you're enrolled in a plan with a defined service area and you move out of that plan's service area. See page 10 for details about how to switch from a Medicare Advantage or Medicare COB HMO.

If any of your primary care physicians (PCPs), specialists, medical groups, Independent Practice Associations (IPAs), hospitals or other providers withdraw from your medical plan during 2015, you will not be able to change medical plans.

Instead, you'll need to obtain services from a participating provider within your plan's network for the rest of the year. The withdrawal of a provider from your plan is not an eligible change-in-status event. For more information about changing coverage midyear, see your copy of the *Summary of Benefits Handbook*.

For Anthem Blue Cross NAP, CAP, ROP and MSP Members

Free Generic Prescription Drugs Through Express Scripts Mail Order

More than 300 generic prescription drugs are available free of charge when you order them through the Express Scripts mail-order prescription drug program. Visit www.express-scripts.com/lowcostgenerics to see a list of free generic mail-order drugs or call Express Scripts at **1-800-718-6590**.

HMOs and Primary Care Physicians (PCPs)

When you first enroll in any type of HMO plan (including a Medicare COB HMO or Medicare Advantage HMO), a primary care physician (PCP) will be assigned to you and any enrolled dependents. You may select a different PCP by contacting your plan's Member Services department.

If you're eligible for Medicare, the PCP you select must be from the HMO's special Medicare provider network, which may be different than the plan's network of doctors for members not enrolled in Medicare. Your PCP must be located within 30 miles of your home—otherwise, the HMO will assign a PCP who is within a 30-mile radius.



Non-Medicare Medical Plan Options

REMINDER:

Are you and your spouse both enrolled in the Kaiser EPO and another Kaiser Plan? Remember—the Kaiser EPO won't coordinate benefits with other Kaiser plans.

If you have other, non-PG&E coverage with Kaiser, you won't receive a benefit from that plan.

EXAMPLE:

If your wife has a Kaiser plan through her non-PG&E employer and you're enrolled as a dependent in her plan—and also as a retiree in the PG&E-sponsored Kaiser EPO—you won't receive any benefits from your wife's Kaiser plan. That's because the PG&E-sponsored Kaiser EPO will pay your benefits, since you're enrolled as a retiree, not as a dependent.

The availability of some medical plans is based on your home ZIP code. Non-Medicare-eligible dependents of Medicare-eligible retirees will be enrolled in the non-Medicare plan that corresponds to the retiree's Medicare plan, as described on page 6. Prescription drug coverage is included in all of the medical plans PG&E sponsors.

Non-Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Cost for Care In addition to your monthly contributions for coverage
Network Access Plan (NAP)*	This Preferred Provider Organization (PPO) plan gives you the flexibility to choose network or non-network providers.**	<ul style="list-style-type: none"> • Annual deductible • Lower out-of-pocket costs when you use network providers
Comprehensive Access Plan (CAP)*	This out-of-area plan is for people who live outside the NAP's service area. This plan lets you use any licensed provider.**	<ul style="list-style-type: none"> • Annual deductible • You may be able to lower your costs by using network providers
Retiree Optional Plan (ROP)*	This plan lets you use any licensed provider.**	<ul style="list-style-type: none"> • Annual deductible • Lower monthly contributions than the NAP and CAP, but higher out-of-pocket costs for services • You may be able to lower your costs by using network providers
Blue Shield and Health Net HMOs and Kaiser Permanente EPO	These plans cover most services in full, but you must use your plan's network of providers located in California to receive coverage.	<ul style="list-style-type: none"> • No deductible • You pay a copayment for office visits and other services • No charge for some services, such as hospital stays

*Under the NAP and CAP, Anthem Blue Cross administers medical benefits and ValueOptions administers mental health and substance abuse benefits. Under the ROP, Anthem Blue Cross administers both medical benefits and mental health and substance abuse benefits. Express Scripts administers prescription drug benefits for the NAP, CAP and ROP.

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

Medicare Medical Plan Options

As a Medicare-eligible participant, (age 65 or older, or under age 65 and on Medicare due to disability), you have a choice of these PG&E-sponsored medical plans, depending on your home ZIP code:

- Comprehensive Access Plan (CAP)
- Medicare Supplemental Plan (MSP)
- Retiree Optional Plan (ROP)
- Medicare Coordination of Benefits (COB) HMO plans
- Medicare Advantage HMO plans

Under the CAP, MSP and ROP, Medicare processes your claims first, except for most prescription drug claims, which will be processed first by Express Scripts. For eligible medical expenses, the CAP, MSP and ROP provide secondary coverage—in other words, these plans process your medical claims after Medicare processes your claims:

- Medicare Parts A and B are considered primary medical coverage.
- The CAP, MSP and ROP provide secondary medical coverage.
- The CAP, MSP and ROP provide primary prescription drug coverage through Express Scripts for most prescription drugs. Medicare provides primary coverage for Medicare Part B drugs, such as diabetic and transplant drugs.

The Medicare COB HMOs and Medicare Advantage HMOs coordinate their benefits with Medicare so you typically don't have to file claims. Special rules apply; please see the table starting on page 11 for details.



SWITCHING FROM A MEDICARE ADVANTAGE OR MEDICARE COB HMO

If you're enrolled in a Medicare Advantage or Medicare COB HMO, you assigned your Medicare medical and prescription drug benefits to the HMO when you enrolled.

This means you gave up control of your Medicare benefits. Only your HMO can use your Medicare benefits; you can't.

Medicare Advantage and Medicare COB HMOs include:

- Kaiser Permanente Senior Advantage (North and South)
- Health Net Seniority Plus
- Blue Shield Medicare COB HMO
- Health Net Medicare COB HMO

If you want to switch out of your Medicare Advantage or Medicare COB HMO into a different PG&E-sponsored medical plan, you'll need to get back control of your Medicare benefits so you can use them.

If you don't receive your disenrollment form within two weeks of your request, call the HR Service Center and ask them to send you another form immediately (contact information is on the back cover).

Follow the steps below:	If you want to switch plans during Open Enrollment:	If you're moving out of your HMO's service area:
1 Elect your new plan.	Do this during Open Enrollment.	Do Steps 1 and 2 BEFORE you move—and at the same time that you call the HR Service Center to change your address.
2 Request the appropriate disenrollment form for your medical plan by calling the HR Service Center. The only way you can get back control of your Medicare benefits is by completing this form. Otherwise, you won't be able to use your Medicare benefits with your new plan.	Do this as soon as you've made your Open Enrollment elections.	You need to do all three things during this call: <ul style="list-style-type: none"> ✓ Change your address ✓ Elect a new medical plan ✓ Request a disenrollment form for your current medical plan
3 Complete the disenrollment form and mail it back to the HR Service Center so they receive it by the deadline listed at the right.	Do this by November 28, 2014.	Do this BEFORE the end of the month in which you report your address change.

IMPORTANT:

If the HR Service Center receives your completed disenrollment form after the deadline, you could have unpaid claims under your new plan—and you'll be responsible for paying those claims.

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
<p>Comprehensive Access Plan (CAP)*</p>	<p>The CAP offers coverage from any licensed physician or hospital.** There is no network of providers, and you don't have to choose a primary care physician.</p> <p>Prescription drug coverage under the CAP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.</p>	<p>The CAP provides secondary coverage to Medicare Parts A and B. It won't pay any amount covered by Medicare, so be sure to enroll in Medicare Parts A and B as soon as you're eligible. If you don't, you'll be responsible for paying any amount Medicare would have covered.***</p>
<p>Medicare Supplemental Plan (MSP)*</p>	<p>The MSP is available only to Medicare-eligible retirees and dependents. It offers coverage from any licensed physician or hospital.** There is no network of providers and you don't have to choose a primary care physician.</p> <p>The MSP pays 80% of eligible expenses not paid by Medicare after you pay a \$100 deductible.</p> <p>Prescription drug coverage under the MSP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.</p>	<p>The MSP has a \$10,000 lifetime maximum medical plan benefit for each member and a separate \$10,000 lifetime maximum for prescription drugs for each member. However, every January, the plan "restores" up to \$1,000 toward each of these two maximums. The lifetime limit does not include amounts paid by Medicare.</p> <p>If you're enrolled in the MSP and you reach the plan's lifetime maximum benefit limit for either medical or prescription drug benefits, you may choose another plan in your ZIP code/service area within 31 days after reaching the limit. Call the HR Service Center as soon as you're notified by either Anthem Blue Cross or Express Scripts that you have exhausted your \$10,000 lifetime maximum benefit limit. You will have to pay any new deductibles in full for the new plan if you switch plans midyear.</p>
<p>Retiree Optional Plan (ROP)*</p>	<p>The ROP lets you use any licensed physician or hospital.** In exchange for lower monthly contributions, you pay higher out-of-pocket costs when you use medical services.</p> <p>The ROP covers most eligible medical expenses at 70% after you meet the plan's deductibles.</p> <p>Prescription drug coverage under the ROP is administered by Express Scripts. There is no direct coordination of benefits with Medicare on prescription drugs except for some drugs covered by Medicare Part B. See the Medical Plan Comparison Charts for details.</p>	<p>The ROP provides secondary coverage to Medicare Parts A and B. It won't pay any amounts covered by Medicare, so be sure to enroll in Medicare Parts A and B as soon as you're eligible. If you don't, you'll be responsible for paying any amounts Medicare would have covered.***</p>

continued on next page

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
<p>Medicare Coordination of Benefits (COB) HMO Plans</p>	<p>PG&E-sponsored Medicare COB HMO plans include:</p> <ul style="list-style-type: none"> • Blue Shield Medicare COB HMO • Health Net Medicare COB HMO <p>Benefits are highest when you use your HMO's network of physicians and hospitals, but you have the option of using licensed providers outside the HMO's network.</p> <p>When you use your HMO's providers, you pay a designated copayment at the time of service. In general, the HMO will coordinate all payments with Medicare and you will not be responsible for any additional payments beyond the designated copayments.</p> <p>When you receive care outside your HMO's network, you'll receive traditional Medicare coverage at the standard level of Medicare benefits.</p> <p>Medicare COB HMO prescription drug coverage: When you enroll in a Medicare COB HMO, you'll receive that HMO's Medicare Part D prescription drug coverage, which is considered an "enhanced" Medicare prescription drug plan. This means that the Medicare COB HMO's Medicare prescription drug plan has better benefits than the standard Medicare prescription drug benefit, without deductibles or gaps in coverage.</p> <p>You should not enroll in Medicare Part D through a separate Medicare prescription drug plan outside of PG&E. If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.</p>	<p>Special enrollment rules: You and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B before you can enroll in a Medicare COB HMO plan.</p> <p>The Medicare COB HMO plans require new enrollees to complete an enrollment application for the plan's Medicare Part D prescription drug coverage. Contact the HR Service Center to request the Medicare Part D prescription drug enrollment application. You'll need to return the completed enrollment application to the HR Service Center. If you don't receive the enrollment application within two weeks of your request, please call the HR Service Center to inquire about the status of your request.</p> <p>If you and your Medicare-eligible dependents are not enrolled in Medicare Parts A and B, or you do not agree to enroll in the HMO's Medicare Part D prescription drug coverage, you won't be able to join the Medicare COB HMO plan. Instead, you'll be enrolled in the CAP, and you'll be responsible for the contributions for that plan.****</p>

IMPORTANT:

If you're already enrolled in a PG&E-sponsored medical plan, do not enroll in any Medicare Advantage plan or Medicare Part D Prescription Drug Plan that is not sponsored by PG&E.

If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.

Medicare Plans	Overview For benefit details, see the Medical Plan Comparison Charts in your enrollment packet	Notes
<p>Medicare Advantage HMO Plans</p>	<p>PG&E-sponsored Medicare Advantage HMO plans include:</p> <ul style="list-style-type: none"> • Kaiser Permanente Senior Advantage (North and South) • Health Net Seniority Plus <p>To receive benefits, you must use your HMO’s network of physicians and hospitals, except for medical emergencies.</p> <p>Medicare Advantage HMO Plans require that you assign or give away control of your Medicare benefits to the HMO. By doing so, you no longer can use your Medicare benefits outside of the Medicare Advantage HMO network. However, the coverage costs for Medicare Advantage HMO plans typically are lower than those for Medicare COB HMO plans.</p> <p>Medicare Advantage HMO prescription drug coverage: When you enroll in a Medicare Advantage HMO, you’ll be automatically enrolled in the Medicare HMO’s Part D prescription drug plan, which is included as part of the Medicare Advantage HMO’s benefits. These drug plans are considered “enhanced” Medicare prescription drug plans, meaning they have better benefits than the standard Medicare prescription drug benefit, without deductibles or gaps in coverage.</p> <p>You should not enroll in Medicare Part D through a separate Medicare prescription drug plan outside of PG&E. If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.</p>	<p>Special enrollment rules: You and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B and you must sign a Medicare Advantage HMO Enrollment form.</p> <p>This form authorizes assignment of your Medicare benefits (Parts A and B) to the HMO and acknowledges your understanding that you will be enrolled in a Medicare Part D prescription drug plan through the HMO. When you enroll, the HR Service Center will send you the appropriate form to complete and return. If you don’t receive the form within two weeks, please call the HR Service Center to inquire about the status of the form.</p> <p>If you and your dependents are not enrolled in Medicare Parts A and B, or you do not agree to complete the Medicare Advantage HMO Enrollment form, you won’t be able to join the Medicare Advantage HMO. Instead, you’ll be enrolled in the CAP, and you’ll be responsible for the contributions for that plan.</p>

*Under the CAP, Anthem Blue Cross administers medical benefits and ValueOptions administers mental health and substance abuse benefits. Under the MSP and ROP, Anthem Blue Cross administers both medical benefits and mental health and substance abuse benefits. Express Scripts administers prescription drug benefits for the CAP, MSP and ROP.

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

***Even if you have Medicare Parts A and B, you still may be required to pay part of the claim for expenses not covered at 100% by the CAP or ROP, like X-rays, which are covered at 90% under the CAP and 70% under the ROP.

****Your covered dependents will be enrolled in the CAP if they are Medicare-eligible or in the NAP if they are not. See the chart on page 6 for corresponding Medicare/non-Medicare plans.

HOW TO REQUEST PART B PREMIUM REIMBURSEMENT CREDITS

Once you're enrolled in Medicare Parts A and B, you must contact the HR Service Center and provide a copy of your Medicare card showing your Medicare claim number and Medicare Part B effective date to qualify for and initiate the monthly reimbursement. PG&E will not issue reimbursement on a retroactive basis, so it's important that you send the HR Service Center a copy of your Medicare card when you first obtain Part B coverage.

The maximum number of reimbursements a family can receive for disabled members is three.

Medicare Part B Reimbursement for Disabled Members under Age 65

In 2015, PG&E will continue to reimburse the standard Medicare Part B premium each month to eligible disabled retirees and up to two disabled dependents who are under age 65, enrolled in Medicare Parts A and B and enrolled in a PG&E-sponsored medical plan.

If you're under age 65 and you believe you or any of your dependents qualify for Social Security due to a disability, please contact Allsup, Inc., at **1-888-339-0743**. PG&E has contracted with Allsup, Inc., to provide Social Security enrollment assistance at no cost to potentially eligible disabled retirees or dependents.

IMPORTANT:

You and Your Covered Dependents Must Enroll in Medicare When Eligible

Be sure to enroll in Medicare Parts A and B as soon as you or your dependents become eligible for Medicare. In addition, if you or a dependent becomes eligible for Medicare due to disability before age 65, you must notify the HR Service Center so your records can be updated and your claims can be properly coordinated with Medicare. The HR Service Center must receive a copy of your Medicare card before PG&E can begin reimbursing you for your Part B premium.

All PG&E-sponsored Medicare plans provide secondary coverage to Medicare Parts A and B. PG&E-sponsored medical plans won't pay any amounts covered by Medicare, even if you're not enrolled in Medicare Parts A and B. To receive full benefits, you need to be enrolled in Medicare Parts A and B.

Typically, you're enrolled automatically in Medicare Parts A and B if you've been receiving Social Security benefits for at least two years. Otherwise, you need to contact the Social Security Administration three months before turning age 65. You must pay a separate premium to the Social Security Administration for Part B coverage.

If you and your Medicare-eligible dependents aren't enrolled in both Medicare Parts A and B when eligible, your PG&E-sponsored medical plan will **not pay the charges** that would otherwise have been covered by Medicare, and you will not be eligible to enroll in a Medicare COB HMO plan or a Medicare Advantage HMO plan. In addition, you will not qualify for Medicare Part B reimbursement from PG&E and you may have to pay Medicare a penalty to obtain Part B coverage.

Prescription Drug Coverage Provided through PG&E-Sponsored Medical Plans

Prescription drug coverage is included in all the medical plans PG&E sponsors. However, there is no direct coordination of benefits with Medicare on prescription drugs, except for some drugs covered by Medicare Part B. Every plan that PG&E offers to Medicare-eligible participants has a higher prescription drug benefit than the basic Medicare Part D prescription drug benefit.

HOW PRESCRIPTION DRUG COVERAGE WORKS IN PG&E-SPONSORED MEDICAL PLANS

You're not enrolled in a Medicare Part D prescription drug plan if you're enrolled in an Anthem plan (CAP, MSP or ROP). Instead, you have prescription drug coverage through Express Scripts:

- CAP members remain in the same prescription drug plan, via Express Scripts, as non-Medicare CAP and NAP members.
- ROP and MSP members are also enrolled via Express Scripts, but they have different levels of coverage than CAP members.

You are enrolled in a Medicare Part D prescription drug plan if you're enrolled in one of the following plans:

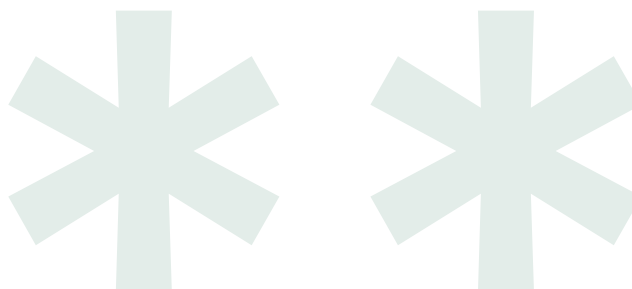
- Medicare COB HMO Plan—Blue Shield Medicare COB Plan or Health Net Medicare COB Plan
- Medicare Advantage HMO Plan—Health Net Seniority Plus Plan or Kaiser Permanente Senior Advantage Plan

For details about prescription drug benefits, see the [Medical Plan Comparison Charts](#).

IMPORTANT:

If you're already enrolled in a PG&E-sponsored medical plan, do not enroll in any Medicare Advantage HMO, Medicare COB HMO or Medicare Part D Prescription Drug Plan that is not sponsored by PG&E.

If you do so, your PG&E-sponsored medical and prescription drug benefits will be terminated.



Your Contributions for Medical Coverage

KEY ACRONYMS

RMEC: Retiree Medical Employer Contribution

RPOA: Retiree Premium Offset Account (available with the RMEC)

RMSA: Retiree Medical Savings Account

If you qualify for PG&E-sponsored retiree medical plan coverage, you and PG&E (or if applicable, a Participating Employer)* share the cost of any PG&E-sponsored coverage.

There are two retiree medical contribution programs:

- **Retiree Medical Employer Contribution (RMEC).** This program is for eligible individuals who retired before 2011.
- **Retiree Medical Savings Account (RMSA).** This program is for eligible individuals who retired in 2011 and later.

Eligible individuals retiring September 2009 through December 2010 were able to choose the RMEC or the RMSA, effective January 1, 2011. This was a one-time, irrevocable choice.

***Note:** As used in this section, the term "PG&E" means a Participating Employer with respect to such employer's employees and retirees. See page 29 for the definition of a Participating Employer.



Retiree Medical Employer Contribution (RMEC) Program

If You Retired Before 2011 or You Elected the RMEC in 2010

Under the RMEC program, PG&E's maximum contributions for retiree medical coverage are limited to set dollar amounts. PG&E pays a portion of the cost of retiree medical coverage up to an annual limit. The amount PG&E contributes toward the cost of your coverage is based on your age, the age of your spouse or domestic partner, whether you're covering any children and your years of credited service. You're responsible for paying the remaining portion of the cost of coverage. PG&E will share in the cost of medical inflation until PG&E contributions reach the new maximum dollar limit under the RMEC. After that point, participants will absorb the entire cost of coverage increases because PG&E's contribution is fixed.

If you're a RMEC participant, PG&E helps pay a portion of your PG&E-sponsored retiree medical plan premiums. You can only use RMEC contributions to pay for PG&E-sponsored retiree medical coverage. You can't use RMEC contributions to pay for any other coverage.

RMEC for Non-Medicare Participants

Each year, PG&E will contribute up to an amount equivalent to 65 percent of the monthly cost of the Anthem Blue Cross-administered NAP or CAP for that year, until the amount PG&E contributes reaches the maximum annual dollar limit. The actual annual dollar limit that PG&E will contribute is based on your years and months of credited service, as described in the column to the right.

If you enroll in another PG&E-sponsored retiree medical plan instead of the NAP or CAP, PG&E will contribute the equivalent amount to the cost of your coverage, provided however, that the maximum PG&E contribution is no more than 72 percent of the monthly cost of coverage for the plan you elect. In other words, non-Medicare retirees and non-Medicare dependents must pay at least 28 percent of their monthly coverage costs.

ACTUAL PG&E CONTRIBUTION BASED ON CREDITED SERVICE

Non-Medicare retirees with 10 to 25 years of service will receive a PG&E contribution ranging from 50 to 65 percent of the cost of NAP or CAP coverage, scaled proportionately based on years and months of credited service. Annual PG&E contributions cannot exceed the following annual maximum limit, also scaled proportionately based on years and months of credited service:

- \$13,000 per enrolled non-Medicare retiree, plus
- \$13,000 per enrolled non-Medicare spouse or registered domestic partner, plus
- \$13,000 total for enrolled non-Medicare children (this limit applies for all of your enrolled children if at least one of your enrolled children is not eligible for Medicare)



RMEC for Medicare Participants

PG&E increases the base monthly contribution each year by the weighted average cost increase of all PG&E Medicare plans based on the prior year's cost experience. For 2015, the base monthly contribution will be \$120.00. The annual increases will continue until the amount PG&E pays for Medicare retirees with 25 or more years of credited service reaches the maximum annual limit. The maximum annual limit is:

- \$2,500 per enrolled Medicare retiree, plus
- \$2,500 per enrolled Medicare spouse or registered domestic partner, plus
- \$2,500 total for enrolled Medicare-eligible children

In addition, PG&E's base monthly contribution for a Medicare retiree with 10 to 25 years of credited service is scaled proportionately, from \$38.41 to \$120.00 in 2015, based on the Medicare retiree's years and months of credited service. Annual PG&E contributions cannot exceed the maximum annual limits, also scaled proportionately based on years and months of credited service.

Medicare retirees with retirement dates in 2003 or earlier who have fewer than 25 years of service will continue to receive the full base PG&E contribution, up to the maximum annual limit.

Separate RMEC Contributions for Retirees and Dependents

Under the RMEC program, PG&E provides separate contributions for retirees, spouses or registered domestic partners and eligible children.

Following the example at the left, PG&E's highest annual contribution toward the cost of PG&E-sponsored retiree coverage would be:

- For Chuck, a Medicare retiree—up to \$2,500 per year, plus
- For Sue, a non-Medicare spouse—up to \$13,000 per year, plus
- For Sarah and Emma, Chuck's non-Medicare children—up to \$13,000 total per year

If Sarah were eligible for Medicare and Emma was not, the total annual limit for Chuck's children still would be \$13,000. The higher total limit applies for all children when at least one is not eligible for Medicare. If both Sarah and Emma were eligible for Medicare, the total limit would be \$2,500.

EXAMPLE:

Medicare-Eligible Chuck and His Family

- Chuck is 67 and retired from PG&E with 26 years of credited service.
- He is eligible for Medicare, but his wife, Sue, and their children are not.
- Chuck's wife and children are enrolled as dependents under his PG&E-sponsored retiree medical coverage.

Retiree Premium Offset Account (RPOA) Available with the RMEC

The RPOA is intended to help retirees reduce the amount they pay for PG&E-sponsored retiree medical plan coverage.

The RPOA is not a medical plan, nor does the account have any cash value. Rather, it's a bookkeeping account containing credits that can be used to help eligible retirees offset, or reduce, their monthly PG&E-sponsored retiree medical plan contributions. The RPOA is fully funded by PG&E, so it costs you nothing. There are two RPOAs: The RPOA50 and the RPOA25. Not all retirees who qualified for the RPOA50 qualified for the RPOA25.

You must be enrolled in a PG&E-sponsored retiree medical plan to take advantage of the RPOA. If you drop your PG&E-sponsored retiree medical coverage for 2015 and enroll in any other medical plan, including an active employee plan, any balance in your RPOA will be frozen. You won't lose your RPOA, but you can't use it to pay for any other coverage. You can only use your RPOA balance to help pay for PG&E-sponsored retiree medical coverage. If you later re-enroll in a PG&E-sponsored retiree medical plan, your RPOA balance will be unfrozen.

RPOA50

Under the RMEC, all retirees who had at least 10 years of credited service were eligible for the RPOA50. The RPOA50 was a one-time allotment of \$500 for each year of credited service beyond your first 10 years of credited service, up to a maximum of \$7,500.

You can use the RPOA50 to offset 50 percent of your monthly retiree medical contributions as long as you have a balance in your RPOA50 allotment.

RPOA25

If you retired on or before January 1, 2007, with 10 or more years of credited service, you may have received an additional RPOA allotment called the RPOA25. After you have depleted your initial RPOA50 allotment, you can use the RPOA25 to offset 25 percent of your cost for PG&E-sponsored retiree medical plan coverage. You cannot use your RPOA25 until your original RPOA50 has been depleted. If you're using the RPOA50 and you deplete that balance, usage of your RPOA25 will automatically begin the month following the month in which your RPOA50 is depleted.

USING YOUR RPOA

Each year during Open Enrollment, if you have a positive RPOA balance, you can elect to start, stop or continue using your RPOA to pay a portion of your retiree medical plan contributions for the upcoming calendar year.

Remember, you must deplete your RPOA50 balance before using your RPOA25. Therefore, if you elect to use your RPOA account and you have a positive RPOA50 balance, you automatically will use the RPOA50 first. If you deplete your RPOA50 balance midyear and you have an RPOA25 balance, you must begin using this balance the following month even if you would prefer to "save" it.



CHANGING YOUR RPOA ELECTION

You may change your RPOA usage election for the coming year by indicating your election during Open Enrollment. If you don't request a change during Open Enrollment, your current RPOA usage election will remain in effect for 2015. After Open Enrollment ends, you may change your RPOA election during the year only if you have an eligible change-in-status event. For details, see your copy of the *Summary of Benefits Handbook*.

If your RPOA balance is depleted during the year, you'll be responsible for paying the full amount of your retiree medical plan contributions through the end of the year. You will not be allowed to switch to a less expensive retiree medical plan during the year if your RPOA account is depleted. If your RPOA account balance is low, you may want to consider switching to a less expensive retiree medical plan during Open Enrollment.

Surviving Dependent Contributions and the RPOA

Surviving dependents pay the full cost of their medical plan coverage. In addition, all surviving dependents are eligible to "inherit" your RPOA balance if all of these conditions are met:

- They became surviving dependents on or after January 1, 2004, and
- You were eligible for the retiree RPOA, and
- An RPOA balance remained at the time of your death.

The surviving dependent can use the "inherited" RPOA balance to reduce the cost of his or her PG&E-sponsored medical coverage until the RPOA balance is depleted or until the surviving dependent is no longer eligible for PG&E-sponsored medical coverage.



Calculating Your RMEC Contributions

Your monthly contribution for retiree medical coverage is the difference between the full cost of coverage for the plan in which you're enrolled and the amount PG&E contributes through the RMEC (and the RPOA, if applicable). You and PG&E share the cost of your PG&E-sponsored retiree medical coverage.

Check your 2015 Enrollment Worksheet to see which plans you're eligible to join and the monthly contributions for each plan.

SAMPLE 2015 MONTHLY COVERAGE COSTS UNDER THE RMEC

If you have an RPOA balance, you may use the account to reduce your monthly contribution for PG&E-sponsored retiree medical coverage. This example is for Tom and Elaine, a retiree* and spouse who have PG&E contributions under the RMEC program and who are both:

- Eligible for Medicare
- Enrolled in the CAP

EXAMPLE: COMPREHENSIVE ACCESS PLAN (CAP)	No RPOA Account Election	Election To Use RPOA50	Election To Use RPOA25
Monthly Cost	\$841.00	\$841.00	\$841.00
PG&E's Contribution	-\$240.00	-\$240.00	-\$240.00
Tom and Elaine's Contribution Without RPOA	\$601.00	\$601.00	\$601.00
RPOA50 or RPOA25 Election	N/A	\$300.50	\$150.25
Tom and Elaine's Net Monthly Contribution	\$601.00	\$300.50	\$450.75

*Assumes Tom has 25 or more years of credited service



Retiree Medical Savings Account (RMSA) Program

LUMP-SUM ALLOTMENT AND THE RMSA

Under the RMSA, all retirees with at least 10 years of credited service can receive an allotment of \$500 for each year of credited service beyond their first 10 years of credited service, up to a maximum lump-sum allotment of \$7,500. This lump-sum allotment will be prorated based on your years of credited service, and will be factored into the total value of your RMSA. It won't be visible as a separate line item on the monthly pension pay statements. Because the additional allotment is included in your total RMSA balance, you'll see one RMSA deduction amount when making your monthly contributions for medical coverage.

If You Retired in 2011 or Later or You Elected the RMSA in 2010

As of January 1, 2011, the RMSA program replaced the RMEC program for eligible individuals who retired in 2011 or later, or who elected the RMSA in 2010. Under the RMSA program, PG&E creates separate accounts for you and your eligible spouse or registered domestic partner at the time you retire. Your enrolled children won't get a separate RMSA, but you can use your RMSA to help pay for their coverage under your PG&E-sponsored retiree medical plan. Only PG&E can credit your RMSA with non-taxable contributions. You may not contribute to your account, as it has no cash value.

The balance in your RMSA is available solely to help you pay for your PG&E-sponsored retiree medical coverage. The amount PG&E contributes toward your RMSA is based on your age and years of service: The more years of service you have and the older you are when you retire, the higher the value of your RMSA. You're responsible for paying the remaining portion of the cost of coverage.

New retirees will receive the RMSA as though it has always been in place. Here's how PG&E contributes to the RMSA:

Your Account— PG&E Contributes:	Your Spouse or Registered Domestic Partner's Account*—PG&E Contributes:
\$5,000 a year to your account for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45)	\$5,000 a year to your spouse or registered domestic partner's account for each year you're employed by PG&E, starting when you reach age 45 (or later if hired after age 45)
Additional \$1,000 a year to your account for each year of credited service beyond 15 years (including credited service before age 45)—credited at retirement	Not applicable
Up to an additional lump sum of \$7,500 to your account based on your years of credited service, prorated from 10 to 25 years of service—credited at retirement (equivalent to the RPOA)	Not applicable
4.5% interest to your account , compounded annually beginning at the end of the year in which you reach age 46	4.5% interest to your spouse or registered domestic partner's account , compounded annually beginning at the end of the year in which you reach age 46

*For your spouse or registered domestic partner to be eligible for the RMSA, you must be married or in your registered domestic partnership on your retirement date.

RMSA Contributions

Each year, the RMSA will pay a monthly percentage of your cost for PG&E-sponsored retiree medical coverage until your account is depleted. At that point, you will pay 100 percent of the cost. The percentage the RMSA will pay depends on what year it is and whether you're eligible for Medicare.

- In 2015, the RMSA will pay 57 percent of the cost of non-Medicare retiree medical coverage and 30 percent of the cost of Medicare retiree medical coverage.
- In 2016 and later, the RMSA will pay 55 percent of the cost of non-Medicare retiree medical coverage and 30 percent of the cost of Medicare retiree medical coverage.

If You Drop Your Retiree Medical Coverage

If you're a PG&E retiree and you decide to drop your PG&E-sponsored retiree medical coverage for 2015 and enroll in any other medical plan, including an active employee plan, any balance in your RMSA will be frozen. You won't lose your RMSA balance, but you can't use it to pay for any other coverage. You can only use it to help pay for PG&E-sponsored retiree medical coverage. Your RMSA balance will be unfrozen if you later re-enroll in a PG&E-sponsored retiree medical plan.

If you're a surviving spouse or dependent and you decide to drop your PG&E-sponsored coverage for 2015, you will not be eligible to enroll in PG&E-sponsored coverage in the future.



Surviving Dependent Contributions and the RMSA

The RMSA of your enrolled surviving spouse or registered domestic partner will continue to help pay for his or her PG&E-sponsored retiree medical coverage as well as the cost of coverage for any enrolled eligible children until:

- The account is depleted
- The enrolled surviving spouse or registered domestic partner becomes eligible for Medicare

Then, your enrolled surviving spouse or registered domestic partner must pay the full cost of coverage.

In addition, your surviving dependents (spouse, registered domestic partner, children) can't use the RMSA to pay for non-PG&E-sponsored health coverage—for example, if they drop PG&E-sponsored coverage or are no longer eligible for PG&E-sponsored coverage.

Calculating Your RMSA Contributions

Your monthly contribution for retiree medical coverage is the difference between the full cost of coverage for the plan in which you're enrolled and the amount PG&E contributes through the RMSA. You and PG&E share the cost of your PG&E-sponsored retiree medical coverage.

Check your 2015 Enrollment Worksheet to see which plans you're eligible to join and the monthly contributions for each plan.



What You Need to Do Now



ENROLL

As a retiree or surviving dependent, you have two ways to enroll:

- **Online through *PG&E@Work For Me* on the Internet.** You can quickly access your benefit options and see your confirmation statement immediately after you've enrolled.
- **By calling the HR Service Center.** Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time.

If you have Internet access, please enroll online. Call volumes are high during Open Enrollment. If you can enroll online, it allows us to serve others who need help.

Enrolling Online During Open Enrollment

To enroll online, you'll need to use Internet Explorer (versions 5.0–8.0):

- Go to <https://myportal.pge.com>. If you're logging on for the first time, click the Help Guides link at the bottom of the page and follow the instructions to access the system.
- Choose the Open Enrollment tab. (see next page)

ENROLLING OR MAKING CHANGES TO YOUR BENEFITS

Annual Open Enrollment is your opportunity to make changes to your benefit coverage. You also get to enroll or make changes when you experience an eligible change-in-status event such as marriage or divorce. You have 31 days to make any allowable midyear changes to your benefits (180 days for the birth or adoption of a child—60 days if you're enrolled in Kaiser Senior Advantage). You must be currently enrolled in a PG&E-sponsored medical plan to request a benefit change due to a change-in-status event. For details about allowable changes, see your copy of the *Summary of Benefits Handbook*.

QUESTIONS?

If you have questions about Open Enrollment or your benefits, contact the HR Service Center:

- Email hrbenefitsquestions@exchange.pge.com (please allow three full business days for a response)
- Call 415-972-7077 or 1-800-700-0057

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

The HR Service Center will be handling a high volume of calls during Open Enrollment. **If possible, please send your questions via email.**

If you don't need assistance, there is no need to call. Simply follow the instructions in your enrollment materials.



IF YOU DON'T ENROLL DURING OPEN ENROLLMENT

If you're currently enrolled and you make no changes to your medical plan or covered dependents, you'll continue to receive your current medical coverage for yourself and your eligible, covered dependents, as listed on the enclosed 2015 Enrollment Worksheet.

If your current medical plan will no longer be available for 2015, your Enrollment Worksheet will show with an asterisk (*) the alternate medical plan you'll receive for 2015 if you don't enroll.

You'll be responsible for making any required contributions for you and your dependents' 2015 medical coverage as listed on your 2015 Enrollment Worksheet.

If you're currently not enrolled in a PG&E-sponsored retiree medical plan and you don't enroll, you will have no coverage for 2015.

Then, follow these steps:

Review your dependents	<p>Make any necessary changes to your dependent information. Have the following information on hand if you want to make a change:</p> <ul style="list-style-type: none"> • Full name, birth date, gender, Social Security number, relationship (for example, spouse, child, registered domestic partner), Medicare Claim Number and effective date for any Medicare-eligible dependents (you can find this on your dependent's Medicare card). <p>Please contact the HR Service Center if you want to add a registered domestic partner or a registered domestic partner's child to your plan, or if you want to add or drop a Medicare-eligible dependent.</p>
Confirm your home address and phone number	<p>Make sure your home address is correct because the availability of some medical plans is based on where you live. If you've moved or you have a new phone number, please email the HR Service Center to update your information.</p> <p>See the back cover for the HR Service Center's contact information.</p>
Enroll	<p>Enroll in the available benefit plan options that best fit your needs and the needs of your family.</p>
Review your confirmation statement	<p>Verify that the options you selected and the dependents you enrolled are shown on your confirmation statement.</p> <ul style="list-style-type: none"> • You can access your confirmation statement through <i>PG&E@Work For Me</i> on the Internet anytime after you enroll. • PG&E also will mail a confirmation statement to your home address or mailing address of record. For Open Enrollment changes, you'll receive your statement in December. For all other midyear enrollments, you'll receive your statement within 10 business days after enrolling. <p>If any of your information appears to be incorrect, call the HR Service Center. Calls must be received within 10 business days of the date you receive your confirmation statement for a midyear change-in-status event or by the last business day of the year for Open Enrollment.</p> <p>All Open Enrollment changes must be made in the current plan year. After December 31, 2014, you cannot make changes for 2015, even if you want to change because of an error on your confirmation statement.</p>
Print your confirmation statement	<p>Keep a copy of your statement for future reference.</p>



Technical Problems?

For help with technical questions about enrolling online, please contact PG&E's Technology Service Center (TSC) by calling **415-973-9000** or **1-800-223-9007**. Representatives are available 24 hours a day, seven days a week.

Details About Your Coverage

There are a lot of details to remember about your coverage. Here are some of the most important points you need to be aware of.

The HR Service Center needs your dependents' correct Social Security numbers.

Please note that federal law (both the Medicare Secondary Payer Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42.U.S.C.1395y(b)(7)&(b)(8) as well as health care reform's health insurance coverage reporting requirements under Internal Revenue Code Section 6055) requires the company to have Social Security numbers (SSNs) on file for individuals enrolled in a PG&E-sponsored medical plan. This includes, among others, retirees and dependents covered under the Pacific Gas and Electric Health Care Plan for Retirees and Surviving Dependents, regardless of age. By enrolling your eligible dependents in PG&E-sponsored health care plans, you agree to provide their SSNs. If you fail to do so, your enrolled dependent(s) may be terminated from medical coverage. If your dependent's correct SSN is missing, please contact the HR Service Center at **415-972-7077** or **1-800-700-0057**, and provide the SSN in order to continue medical coverage for that dependent.

Are you a surviving dependent of an employee or retiree?

If you're a surviving dependent of an employee or retiree (if you're a spouse, registered domestic partner or eligible child), you're eligible for continued medical plan coverage if you were enrolled in a PG&E-sponsored medical plan at the time of the employee or retiree's death and you're not covered under another group plan, other than Medicare. If you're a surviving child, you must meet additional eligibility requirements (contact the HR Service Center for more information).

If you marry or enter into a domestic partnership, you'll no longer be eligible for PG&E-sponsored coverage—even if your new spouse or domestic partner has no other coverage. To avoid penalties, notify the HR Service Center as soon as you marry or enter into a domestic partnership.



REMEMBER

YOU CAN ENROLL YOUR CHILDREN UP TO AGE 26

You can enroll your children up to age 26 for PG&E-sponsored medical coverage as long as they are not eligible for coverage under another employer-sponsored health plan (except for a plan of their other parent). If you have questions, contact the HR Service Center.



Are you a retiree who cancelled your PG&E coverage?

If you opted out of your PG&E-sponsored medical coverage on or after January 1, 2003, and you didn't call the HR Service Center to request an Open Enrollment packet by September 1 of this year, your next opportunity to re-enroll in a PG&E-sponsored retiree medical plan will be next fall for coverage effective January 1, 2016. You'll need to call the HR Service Center by September 1, 2015, to initiate re-enrollment for 2016.

If you don't enroll for retiree medical coverage in 2015 and you don't notify the HR Service Center by September 1, 2015, that you want retiree medical coverage for 2016, you won't be able to re-enroll for 2016—even if you cancelled PG&E-sponsored coverage because you had other medical coverage and you subsequently lost that other coverage.

The only exception is for a retiree enrolled as a dependent of an active PG&E employee in a PG&E-sponsored medical plan. If you lose your dependent coverage midyear, you can enroll in retiree coverage midyear and you won't need to wait until the next Open Enrollment period to enroll.

Note: The following people can't ever re-enroll for PG&E-sponsored retiree medical coverage:

- Retirees who dropped PG&E-sponsored retiree medical coverage before January 1, 2003
- Surviving spouses or dependents who dropped PG&E-sponsored retiree medical coverage at any time



Is your dependent child disabled?

If you have a disabled dependent under age 26 who is 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 medical coverage from age 26 onward. You'll need to get the certification directly from your medical plan. This is the only way your disabled child can stay enrolled as your dependent in a PG&E-sponsored medical plan from age 26 onward.

If you don't get the medical certification before your child turns 26, then he or she will no longer be eligible for PG&E-sponsored coverage—and must be dropped from coverage by the first of the month following the month in which he or she turns 26. You also may have to periodically attest to ongoing eligibility based on disability, after the initial certification.

Did you skip a premium payment or enroll an ineligible dependent?

If you're a retiree or surviving dependent and you don't pay your medical plan contributions or any required restitution for covering ineligible dependents, your coverage will be permanently cancelled and you won't be able to re-enroll in a PG&E-sponsored medical plan again.

It's your responsibility to make sure all dependents you enroll for coverage are eligible. You must drop dependents from coverage within 31 days of the date on which they become ineligible for coverage. All participants who cover ineligible dependents will be required to make restitution to the Participating Employer* for health care coverage, up to two full years' of the cost of coverage. To drop ineligible dependents, call the HR Service Center at the phone number shown on the back cover.

COVERING DISABLED DEPENDENTS

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 can't cover disabled dependents age 26 or older if they fail to meet either one of these conditions.



*The Participating Employers offering health coverage for 2015 are Pacific Gas and Electric Company (PG&E); PG&E Corporation; PG&E Corporation Support Services, Inc.; and PG&E Corporation Support Services II, Inc.

Member Services Information

PLAN AND CONTACT INFORMATION		
MEDICAL	CONTACT	GROUP NUMBER
Blue Shield HMO and Medicare Coordination of Benefits (COB) HMO Representatives are available: <ul style="list-style-type: none"> Monday–Thursday, 7 a.m.–7 p.m. Pacific Time Friday, 9 a.m.–7 p.m. Pacific Time 	1-888-235-1765 www.blueshieldca.com/pge	H11473
Health Net HMO Representatives are available Monday–Friday, 8 a.m.–6 p.m. Pacific Time	1-800-522-0088 www.healthnet.com	68992N
Health Net Medicare Coordination of Benefits (COB) HMO Medical questions: Health Net representatives are available Monday–Friday, 8 a.m.–6 p.m. Pacific Time Pharmacy questions: SilverScript representatives are available 24/7; closed Thanksgiving and Christmas	Medical questions: 1-800-522-0088 Pharmacy questions: 1-888-648-9626 www.healthnet.com	68992M
Health Net Seniority Plus Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time	Current members: 1-800-275-4737 Prospective members: 1-800-596-6565 www.healthnet.com	68992S
Kaiser Permanente EPO (North and South) Representatives are available: <ul style="list-style-type: none"> Monday–Friday, 7 a.m.–7 p.m. Pacific Time Saturday and Sunday, 7 a.m.–3 p.m. Pacific Time 	NORTH: 1-800-663-1771 SOUTH: 1-800-533-1833 www.my.kp.org/ca/pge	NORTH Corporation: 738-003 Utility: 603702 SOUTH Corporation: 107932-5 Utility: 231142
Kaiser Permanente Senior Advantage (North and South) Representatives are available Monday–Friday, 8 a.m.–5 p.m. Pacific Time	1-800-443-0815 www.my.kp.org/ca/pge	NORTH: 738 SOUTH: 107932
Hearing Aid Reimbursement for Blue Shield and Kaiser Senior Advantage Plans Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time	Contact Your Spending Account (YSA) 1-800-964-9902 www.yourspendingaccount.com/pge	N/A
Anthem Blue Cross-Administered Plans: Network Access Plan (NAP) Comprehensive Access Plan (CAP) Retiree Optional Plan (ROP) Medicare Supplemental Plan (MSP) Representatives are available Monday–Friday, 7 a.m.–8 p.m. Pacific Time	1-800-964-0530 www.anthem.com/ca/pge	PZG170157

PLAN AND CONTACT INFORMATION		
PRESCRIPTION DRUG	CONTACT	GROUP NUMBER
<p>Prescription Drug Plan Administered by Express Scripts For NAP, CAP, ROP and MSP Representatives are available 24/7; closed Thanksgiving and Christmas</p>	<p>1-800-718-6590 www.express-scripts.com</p>	PGE0000
<p>Prescription drug benefits for the HMOs are included in the HMO plans.</p>	N/A	N/A
MENTAL HEALTH AND SUBSTANCE ABUSE	CONTACT	GROUP NUMBER
<p>Mental Health and Substance Abuse (MHSA) Program Administered by ValueOptions For NAP, CAP, all HMOs (including Medicare COB HMOs and Medicare Advantage HMOs), Kaiser EPO Representatives are available 24/7</p>	<p>1-800-562-3588 www.valueoptions.com</p>	N/A
OTHER BENEFITS	CONTACT	GROUP NUMBER
<p>COBRA Administered by Ceridian Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time</p>	<p>1-800-877-7994 www.ceridian-benefits.com</p>	N/A
<p>Health Savings Account Administered by UMB Bank Representatives are available: • Monday–Friday, 5 a.m.–5:30 p.m. Pacific Time • Saturday, 6 a.m.–3 p.m. Pacific Time</p>	<p>1-866-520-4HSA (4472)</p>	N/A
<p>Tobacco Cessation Program Administered by Provant Health Solutions Representatives are available Monday–Friday, 5 a.m.–5 p.m. Pacific Time</p>	<p>1-866-271-8144</p>	N/A
<p>Allsup, Inc. Social Security Advocacy: Help enrolling in Medicare for potentially eligible disabled retirees and dependents Representatives are available Monday–Friday, 6 a.m.–3 p.m. Pacific Time</p>	<p>1-888-339-0743</p>	N/A

PG&E Benefits Information and References

<p>PG&E HR Service Center For benefit and enrollment questions Representatives are available Monday–Friday, 7:30 a.m.–5 p.m. Pacific Time</p>	<p>hrbenefitsquestions@exchange.pge.com 415-972-7077 or 1-800-700-0057</p>
<p>PG&E Technology Service Center (TSC) For help logging in to <i>PG&E@WorkForMe</i> Representatives are available 24 hours a day, 7 days a week</p>	<p>415-973-9000 or 1-800-223-9007</p>
<p><i>PG&E@Work For Me</i> on the Internet</p>	<p>https://myportal.pge.com</p>
<p>PG&E's <i>Summary of Benefits Handbook</i></p>	<p>Go to <i>PG&E@Work For Me</i> > Open Enrollment > Related Links. Contact the HR Service Center to request a free copy.</p>
<p>PG&E Pension Center To change your address, request direct deposit and change your tax withholding information</p>	<p>https://pgepensioncenter.com</p>
<p>IRS Publications</p>	<p>www.irs.gov 1-800-829-3676</p>
<p>Social Security Administration</p>	<p>www.socialsecurity.gov 1-800-772-1213</p>
<p>Medicare</p>	<p>www.medicare.gov 1-800-MEDICARE (1-800-633-4227)</p>

